10381

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 13

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH: COUNTY Anne Arundel; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Ferndale; MARYLAND; LENGTH OF STAY (In this place) 14 years; HOSPITAL OR INSTITUTION OR STREET ADDRESS 100 First Ave. South

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY A. A.; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Ferndale; STREET ADDRESS (If rural, give location) 100 First Ave.

3. NAME OF DECEASED (Type or Print): (First) WILLIAM (Middle) MILTON (Last) BARRETT

4. DATE OF DEATH: (Month) NOV. (Day) 16 (Year) 1949

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: Apr. 9. 1888

9. AGE Last birthday: 61 yrs. If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Oyster

10b. KIND OF BUSINESS OR INDUSTRY: Sea. food

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: WILLIAM M. Barrett Sr.

14. MOTHER'S MAIDEN NAME: Sarah Ledley

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): None

16. SOCIAL SECURITY NO.

17. INFORMANT: Mrs. W. M. Barrett.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
434.2 Immediate cause	(a) Coronary Thrombosis	3 hours
94a Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Coronary sclerosis	unknown
	(c) Cardiac asthma	4 years
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	General Arterio. sclerosis & Hypertension	5 year

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☑

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at work ☐ Not while at work ☐ | HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE (Degree or title) | ADDRESS | DATE SIGNED

John M. Caffy M.D. Deputy Medical Examiner Annapolis Md. 11/16/49

23. BURIAL, CREMATION, REMOVAL (Specify): BURIAL | DATE THEREOF: Nov. 19, 1949 | NAME OF CEMETERY OR CREMATORY: MT. OLIVET. | LOCATION (City, town, or county) (State): BALTIMORE, MD.

DATE REC'D BY LOCAL REG. 11/16/49 | REGISTRAR'S SIGNATURE: L. J. D'Alba | 24. FUNERAL DIRECTOR: Thomas W. Singleton | ADDRESS: Glen Burnie, Md.

VS-A15A

RECEIVED
SEP 18 1969
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

10382

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY: Anne Arundel — STATE: MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Maryland — COUNTY: Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Eastport, Md. — LENGTH OF STAY (in this place): 8 Yrs.	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Eastport Near Annapolis, Md.
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 320 Chester Ave.	STREET ADDRESS (If rural give location): 320 Chester Ave.

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Mary		Blunt	11/	24	1949

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months / Days	If under 24 hrs.: Hours / Min.
Female	Colored	Widowed	10/ 8/1883	66 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Domestic	None	North Carolina	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Elija Simpson	Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
No	None	Jennie Wilson

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

492 **Immediate cause** (a) Pneumonitis

109 **Antecedent cause(s)** Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from 11-12, 1949, to 11-24, 1949, that I last saw the deceased alive on 11-23, 1949, and that death occurred at 1:55 P. m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
V. T. Allen	M D	10 Arnold	11-26-49

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	11/ 27/ 1949	Brewer Hill Cemetery	West St. Annapolis, Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Nov. 26, 1949		Mrs. Charles E. Hicks & Son	45 Northwest St.

RECEIVED
NOV 29 1949
BUREAU V. S.

Evidence for change of age shown on:

FILM No. G 123 DEC 7 1949

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

10383

CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH · COUNTY: Anne Arundel — MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED · STATE: Maryland — COUNTY: Balto City
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Crownsville — LENGTH OF STAY (in this place): 6 yr. 3 mos.	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Baltimore
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Crownsville State Hosp., Md.	STREET ADDRESS (If rural, give location): 1021 Hillen Street

3. NAME OF DECEASED (Type or Print) (First) Lula (Middle) (Last) Brown			4. DATE OF DEATH (Month) (Day) (Year) 19 11/26/49		
5. SEX: Female	6. COLOR OR RACE: colored	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) married	8. DATE OF BIRTH: 1898	9. AGE last birthday: ~~53~~ 51 yrs.	If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housework	10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country): Virginia	12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME: James Coleman			14. MOTHER'S MAIDEN NAME: Anna Cook		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)		16. SOCIAL SECURITY No.	17. INFORMANT AND ADDRESS: Hospital		

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Cerebral Hemorrhage since 12 hours

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c) Cerebral Arteriosclerosis known since 8/27 1943

331

83a

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☒ Not While at Work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8/27/43, 19....., to 11/26, 1949, that I last saw the deceased alive on 11/26/, 19 49 and that death occurred at 7:15 A. M., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Jacob Frangcuster	M.D.	Crownsville, Maryland	11/26/49

23. BURIAL, CREMATION REMOVAL (Specify): Burial	DATE: 11/29/49	NAME OF CEMETERY OR CREMATORY: Mt Auburn	LOCATION (City, town, or county) (State): md
DATE REC'D BY LOCAL REG.: 11/28/49	REGISTRAR'S SIGNATURE: A. W. Hagner	24. FUNERAL DIRECTOR: Geo H. G. Kelson	ADDRESS: 1303 Preistman st

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

10384

CERTIFICATE OF DEATH

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Anne Arundel County; MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis Md
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Annapolis Emergency Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md COUNTY do
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberstone Md
STREET ADDRESS (If rural, give location) Franklin and Cathedral Streets

3. NAME OF DECEASED (Type or Print): (First) Jack (Middle) (Last) Brown

4. DATE OF DEATH: (Month) Nov. (Day) 20 (Year) 1949

5. SEX: Male

6. COLOR OR RACE: Colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed

8. DATE OF BIRTH: 1870

9. AGE last birthday: 79 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farm hand

10b. KIND OF BUSINESS OR INDUSTRY: Farming

11. BIRTHPLACE (State or foreign country): Unknown

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT AND ADDRESS: Geo. Crowner, Galesville Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Circulatory collapse — 6 hours

177 Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last — 51b

(b) Uremia — 2 days

(c) Carcinoma of prostate gland — unknown

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Severe pyuria with probable renal involvement

19a. DATE OF OPERATION: Nov. 15. 49

19b. MAJOR FINDINGS OF OPERATION: Moderately distended bladder — Suprapubic cystostomy

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At wnrk ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Nov. 9, 1949, to Nov. 20, 1949, that I last saw the deceased alive on Nov. 12, 1949, and that death occurred at 11:05 A. m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Donald H. Hooker, M.D. 53 Cornhill St. Annapolis, Md. 21 Nov 49.

23. BURIAL, CREMATION REMOVAL (Specify): Burial

DATE: Nov 23 1949

NAME OF CEMETERY OR CREMATORY: Daniel Star

LOCATION (City, town, or county) (State): West River Md

DATE REC'D BY LOCAL REG.: Nov. 23, 1949

REGISTRAR'S SIGNATURE: [signature]

24. FUNERAL DIRECTOR: T A Hardesty & Son

ADDRESS: Galesville, Md.

RECEIVED
NOV 25 1949
BUREAU OF S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

10385

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Johnson's Mat. Hosp.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY A. G.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED (Type or Print) (First) Baby (Middle) Thomas (Last) Brown

4. DATE OF DEATH (Month) 11 (Day) 8 (Year) 1949

5. SEX Male
6. COLOR OR RACE Negro
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single
8. DATE OF BIRTH 11-7-49
9. AGE last birthday yrs. If under 1 year Months Days 1 If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Johnson's Mat. Clinic
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Thomas Brown
14. MOTHER'S MAIDEN NAME Alice Johnson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Alice Brown

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

754.4 Immediate cause (a) Congenital Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: 2 days.

157e Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 11/7/49, 19....., to 11/8/49, 19....., that I last saw the deceased alive on 11/8/49, 19....., and that death occurred at ..... m., from the causes and on the date stated above.

SIGNATURE Theodore H. Johnson M.D. (Degree or title) ADDRESS 40 Northwest Street DATE SIGNED 11/8/49

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE THEREOF 11-9-49
NAME OF CEMETERY OR CREMATORY Davidsonville
LOCATION (City, town, or county) Davidsonville (State) Md.

DATE REC'D BY LOCAL REG. Nov. 9, 1949
REGISTRAR'S SIGNATURE [signature]
24. FUNERAL DIRECTOR William Reese, II
ADDRESS Annapolis, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
NOV 10 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

10386

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15A

1. PLACE OF DEATH: COUNTY Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS A.A. General Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY A. A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
STREET ADDRESS (If rural, give location) Route 3 Spa Road

3. NAME OF DECEASED (Type or Print): (First) JAMES (Middle) F. (Last) BULLEN
4. DATE OF DEATH: (Month) Nov. (Day) 24 (Year) 1949

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: MAR. 28 1886
9. AGE last birthday: 63 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Cutter
10b. KIND OF BUSINESS OR INDUSTRY: State Roads Comm.
11. BIRTHPLACE (State or foreign country): Md
12. CITIZEN OF WHAT COUNTRY: USA

13. FATHER'S NAME: John Fletcher Bullen
14. MOTHER'S MAIDEN NAME: Lydia Jane Tarr

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Mrs John A Bullen

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

965 **Immediate cause** (a) Fractured skull

1700 **Antecedent cause(s)** Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Compound fractures of both legs + hands

(c) Hemorrhage

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☑

21. EXTERNAL CAUSE WAS PRIMARY ☑ OR CONTRIBUTING ☐ CAUSE OF DEATH.
PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY
(CITY OR TOWN) near Annapolis (COUNTY) AA (STATE) Md.
TIME OF INJURY (Month) Nov. (Day) 24 (Year) 1949 (Hour) m.
INJURY OCCURRED While at work ☐ Not while at work ☑
HOW DID INJURY OCCUR? Hit by Taxi - Cab

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE (Degree or title) ADDRESS DATE SIGNED
John M. Caffey M.D. Deputy Medical Examiner Annapolis Md 11/24/49

23. BURIAL, CREMATION, REMOVAL? (Specify) Burial
DATE THEREOF 11-27-49
NAME OF CEMETERY OR CREMATORY Dunker Cemetery
LOCATION (City, town, or county) (State) Galesville, Md

DATE REC'D BY LOCAL REG. Nov. 26, 1949
REGISTRAR'S SIGNATURE
24. FUNERAL DIRECTOR ADDRESS
B. L. Hopping & Son Annapolis Md

RECEIVED
NOV 29 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

10387

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY A. A. MARYLAND Md.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Emergency Hospt.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY aa
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
STREET ADDRESS (If rural, give location) 14 Hyde

3. NAME OF DECEASED (Type or Print) (First) Pauline (Middle) Virginia (Last) Burroughs

4. DATE OF DEATH (Month) 11 (Day) 15 (Year) 1949

5. SEX 7

6. COLOR OR RACE W.

7. ~~SINGLE~~, MARRIED, ~~WIDOWED~~, ~~DIVORCED~~, (Specify)

8. DATE OF BIRTH 8-12-1895

9. AGE last birthday 54 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife

10b. KIND OF BUSINESS OR INDUSTRY —

11. BIRTHPLACE (State or foreign country) St Marys Co.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME George Armaworthey

14. MOTHER'S MAIDEN NAME Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. —

17. INFORMANT Joe Clyde Burrough Annapolis Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

			INTERVAL BETWEEN ONSET AND DEATH
331	Immediate cause	(a) Cerebral Hemorrhage	11-14-49
956	Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Rheumatic Heart Disease	15 years
		(c) Hypertension	unknown

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from ....., 1938, to Nov 15, 1949, that I last saw the deceased alive on Nov 14, 1949, and that death occurred at 2:30 A.m., from the causes and on the date stated above.

SIGNATURE George C Basil (Degree or title) M.D. ADDRESS Annapolis Md DATE SIGNED 11-15-49

23. BURIAL, ~~CREMATION~~ ~~REMOVAL~~ (Specify) DATE THEREOF 11-17-49 NAME OF CEMETERY OR CREMATORY St Marys LOCATION (City, town, or county) Annapolis (State) Md

DATE REC'D BY LOCAL REG. Nov. 17, 1949 REGISTRAR'S SIGNATURE [signature] 24. FUNERAL DIRECTOR John M. Taylor Sons ADDRESS Annapolis Md

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
NOV 18 1949
BUREAU V. S.

Evidence for change of age shown on:

FILM No. G 123 DEC 5 1949

10388

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Balt, City
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Crownsville — LENGTH OF STAY (in this place) 1 yr. 5 mos.	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore
HOSPITAL OR INSTITUTION OR STREET ADDRESS Crownsville State Hospital Crownsville, Maryland	STREET ADDRESS (If rural, give location) 701 W. Freemont Avenue

3. NAME OF DECEASED (Type or Print)	(First) Henry	(Middle)	(Last) Chester	4. DATE OF DEATH	(Month) 11/19/49 (Day) (Year) 19
5. SEX male	6. COLOR OR RACE colored	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) single	8. DATE OF BIRTH 1889	9. AGE last birthday ~~61~~ 60 yrs.	If under 1 year Months. Days; If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer	10b. KIND OF BUSINESS OR INDUSTRY none	11. BIRTHPLACE (State or foreign country) Baltimore, Md.	12. CITIZEN OF WHAT COUNTRY? U.S.		
13. FATHER'S NAME Castor Chester	14. MOTHER'S MAIDEN NAME not known				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, ~~or unknown~~) ~~(If yes, give war or dates of service)~~	16. SOCIAL SECURITY No. *******	17. INFORMANT Hospital			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Tuberculosis of the Lungs	known since 11/4/49
002 Antecedent cause(s)		
13b Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b)	
	(c) Paranoid Condition	known since 6/15/49

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION *******	19b. MAJOR FINDINGS OF OPERATION *******	20. AUTOPSY? Yes ☐ No ☐
21. ACCIDENT SUICIDE HOMICIDE (Specify) ****	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) ****	(CITY OR TOWN) ***** (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) **** m.	INJURY OCCURRED While at Work ☒ Not While At work ☐	HOW DID INJURY OCCUR? *****

22. I hereby certify that I attended the deceased from 6/15/49, 19....., to 11/19/49, 19....., that I last saw the deceased alive on 11/19/49, 19....., and that death occurred at 1:30 A.M., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Jacob Marquette M.D.		Crownsville, Maryland	11/10/49

23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE 11-23-1949	NAME OF CEMETERY OR CREMATORY Mt Auburn Cem.	LOCATION (City, town, or county) Balto.	(State) Md.
DATE REC'D BY LOCAL REG. 11/22/49	REGISTRAR'S SIGNATURE Geo. Hedrick D.M.	24. FUNERAL DIRECTOR Mrs Katie R. Williams	ADDRESS 322 N Schroeder St	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

10389

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Anne Arundel; MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis; LENGTH OF STAY (in this place) - - -
HOSPITAL OR INSTITUTION OR STREET ADDRESS U.S.Naval Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN RURAL - Annapolis
STREET ADDRESS (If rural give location) Route #4

3. NAME OF DECEASED (Type or Print): (First) William (Middle) Price (Last) CLARKE
4. DATE OF DEATH: (Month) 11 (Day) 9 (Year) 1949

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married
8. DATE OF BIRTH: 6-22-1893
9. AGE last birthday: 56 yrs. If under 1 year: Months, Days. If under 24 hrs.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Rear Admiral - Retired
10b. KIND OF BUSINESS OR INDUSTRY: USN
11. BIRTHPLACE (State or foreign country): California
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Charles Oliver Clarke
14. MOTHER'S MAIDEN NAME: Helen Price Coles

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): WW I
16. SOCIAL SECURITY NO. - - - - - - - - -
17. INFORMANT: Hospital Records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

420.0 Immediate cause (a) THROMBOSIS, CORONARY ARTERY — Spontaneous

93d Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) ARTERIOSCLEROTIC HEART DISEASE — Years

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: None
19b. MAJOR FINDINGS OF OPERATION: -
20. AUTOPSY? Yes ☒ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): None
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): - - - - - -
(CITY OR TOWN) (COUNTY) (STATE): - - - - - - - - - - - - - - - - - -
TIME OF INJURY (Month) (Day) (Year) (Hour): - - - - - - m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR? -

22. I hereby certify that I attended the deceased from 11-7-, 1949, to 11-9-, 1949, that I last saw the deceased alive on 11-9-, 1949, and that death occurred at 7:10 A.m., from the causes and on the date stated above.

SIGNATURE: J. M. Benavides
(Degree or title): LTJG., MC, USNR
ADDRESS: U.S.Naval Hospital, Annapolis, Md.
DATE SIGNED: 11-9-49

23. BURIAL, CREMATION REMOVAL (Specify)
DATE THEREOF: 11-11-49
NAME OF CEMETERY OR CREMATORY: Naval Academy
LOCATION (City, town, or county) (State): Annapolis Md.

DATE REC'D BY LOCAL REG.: Nov. 10, 1949
REGISTRAR'S SIGNATURE: [illegible]
24. FUNERAL DIRECTOR: John M. Taylor Son
ADDRESS: Annapolis Md.

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BUREAU U. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

10390

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH · COUNTY Anne Arundel MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED · STATE Maryland COUNTY Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis — LENGTH OF STAY (in this place) Life	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
HOSPITAL OR INSTITUTION OR STREET ADDRESS 50 Pleasant Street	STREET ADDRESS (If rural give location) 50 Pleasant Street

3. NAME OF DECEASED (Type or Print)	(First) Annie	(Middle) Elizabeth	(Last) Clemans	4. DATE OF DEATH	(Month) 11- (Day) 14 (Year) 1949
5. SEX Female	6. COLOR OR RACE Colored	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH 4/ 15/ 1875	9. AGE last birthday 74 yrs.	If under 1 year Months Days; If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic	10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (State or foreign country) Anne Arundel Co. Md.	12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME Edward Watkins	14. MOTHER'S MAIDEN NAME Louise Stevens				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)	16. SOCIAL SECURITY No. None	17. INFORMANT Marie Holmes			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Bronchon Pneumonia	7 days
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Influenza	4 days
	(c)	

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II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 11/12, 1949, to 11/14, 1949, that I last saw the deceased alive on 11/14/49, 19....., and that death occurred at 2:40 p m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
R. L. [illegible]	M.D.	110 - Clay St. [illegible]	11/16/49

23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE THEREOF 11/ 18/1949	NAME OF CEMETERY OR CREMATORY Brewer Hill Cemetery	LOCATION (City, town, or county) (State) West St Extended- Annapolis
DATE REC'D BY LOCAL REG. Nov. 17, 1949	REGISTRAR'S SIGNATURE [signature]	24. FUNERAL DIRECTOR Mrs. CharlesE. Hicks & Son-	ADDRESS 45 Northwest St.

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MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

10391

CERTIFICATE OF DEATH

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING — PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH
COUNTY: Anne Arundel Co. STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Brownse Woods
LENGTH OF STAY (in this place): Life
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Browns Woods near Annapolis

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland COUNTY: Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Browns Woods near Annapolis
STREET ADDRESS (If rural give location): Browns Woods Near Annapolis

3. NAME OF DECEASED (Type or Print): (First) Gertrude (Middle) Henson (Last) Colbert

4. DATE OF DEATH: (Month) 11/ (Day) 21 (Year) 19 49

5. SEX: Female

6. COLOR OR RACE: Colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed

8. DATE OF BIRTH: 4/ 15/1878

9. AGE last birthday: 71 yrs. If under 1 year: Months ___ Days ___ If under 24 hrs.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Domestic

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? ---

13. FATHER'S NAME: Henry Cook

14. MOTHER'S MAIDEN NAME: Henretta Stansberry

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: ---

17. INFORMANT: Bernard Henson

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

334 Immediate cause (a) Hypertensive Encephalopathy

8?2 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 11-16, 19 49, to 11-21, 19 49, that I last saw the deceased alive on 11-16, 19 49, and that death occurred at 7:30 A m., from the causes and on the date stated above.

SIGNATURE: A. T. Allen (Degree or title) M D ADDRESS: 10 Carroll DATE SIGNED: 11-23-49

23. BURIAL, CREMATION, REMOVAL (Specify): Burial | DATE THEREOF: Nov 23/ 1949 | NAME OF CEMETERY OR CREMATORY: Broad Neck Cemetery | LOCATION (City, town, or county) (State): Skidmore Near Annapolis, Md.

DATE REC'D BY LOCAL REG.: Nov 23, 1949 | REGISTRAR'S SIGNATURE: [signature] | 24. FUNERAL DIRECTOR ADDRESS: Mrs. Charles E. Hicks &Son- 43-45 Northwest St. Annapolis, Maryland

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MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

10392

CERTIFICATE OF DEATH

Reg. Dist. No. 20

1. PLACE OF DEATH:

County: Anne Arundel

City or town: McKendree (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: McKendree (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war: none

3. (a) FULL NAME: Vetura Ann Crandell

3. (b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: Julius E. Crandell

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): March 19, 1860

8. AGE: Years	Months	Days	If less than one day
89	7	13	..... hrs. ..... min.

9. Birthplace: McKendree (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER
12. Name: John Wayson
13. Birthplace: Md.

MOTHER
14. Maiden name: Elizabeth Stallings
15. Birthplace: Md.

16. Informant: Mrs. Elsie Ireland
Address: Lothian, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov. 5. 1949 (month) (day) (year)

Cemetery or crematory: Mt. Zion
Location: Lothian, Md.

18. Funeral director: T. A. Hardesty & Son
Address: Galesville, Md.

19. 11/4 1949 (Date rec'd by registrar) W. R. Clayton Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 2 Nov 1949, at 3 00 p M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 1947 19 to 2 Nov 1949 and that I last saw her alive on 30 Oct 1949

Immediate cause of death	DURATION
Cachexia	6 mos
Due to Generalized Arteriosclerosis + markedly severe	20 yrs
Due to 450.0	
Other conditions 97 (Include pregnancy within 3 months of death)	

Major findings of operations ..... Date of op.

Autopsy results: none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ..... Injured at work?

23. SIGNATURE: R B Tasser, M D M. D. ~~or other~~

Address: Upper Marlboro, Md. Date signed: 2 Nov 49

MARYLAND STATE DEPARTMENT OF HEALTH

10393

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 20

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH: COUNTY: Anne Arundel — STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Edgewater — LENGTH OF STAY (in this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Central Ave. nr Mayo Rd.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Maryland — COUNTY: Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Edgewater
STREET ADDRESS (If rural give location): Central Ave. nr Mayo Rd.

3. NAME OF DECEASED (Type or Print): (First) Wallace (Middle) M. (Last) Dixon

4. DATE OF DEATH: (Month) November (Day) 8, (Year) 1949

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: Dec 30, 1869

9. AGE last birthday: 79 yrs. If under 1 year: Months 10 Days 8 If under 24 hrs.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Poltry Dealer

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland Calvert Co

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Benjamin F. Dixon

14. MOTHER'S MAIDEN NAME: Susan Phipps

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Florence V. Dixon

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Generalized Arteriosclerosis — Several years.

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last — (b) Hypertension — 6 years.

447 94

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY: (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Nov 5, 1949, to Nov 8, 1949, that I last saw the deceased alive on Nov 7, 1949, and that death occurred at 5 P.M., from the causes and on the date stated above.

SIGNATURE: George C. Basil (Degree or title) M.D. ADDRESS: Annapolis Md DATE SIGNED: 11-9-49

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE THEREOF: 11-10-49 — NAME OF CEMETERY OR CREMATORY: Christ Episcopal Cemetery — LOCATION (City, town, or county) (State): Owensville, Md.

DATE REC'D BY LOCAL REG.: Nov. 10, 1949 — REGISTRAR'S SIGNATURE: Edward Collmus

24. FUNERAL DIRECTOR: B.I. Hopping and Son — ADDRESS: Annapolis, Md

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 26

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY A.A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Shady Side — LENGTH OF STAY (in this place) 5 years	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Shadyside Md
HOSPITAL OR INSTITUTION OR STREET ADDRESS	STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print)	(First) Frank	(Middle) D.	(Last) Ellermann	4. DATE OF DEATH	(Month) Nov. (Day) 26 (Year) 1949
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, ~~MARRIED~~, ~~WIDOWED~~, ~~DIVORCED~~, ~~(Specify)~~	8. DATE OF BIRTH Aug 10, 1886	9. AGE last birthday 63 yrs.	If under 1 year: Months, Days; If under 24 hrs.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Supervisor Plant Protection	10b. KIND OF BUSINESS OR INDUSTRY Bethlehem Steel Co.	11. BIRTHPLACE (State or foreign country) Balto	12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Frank Ellerman	14. MOTHER'S MAIDEN NAME Unknown				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)	16. SOCIAL SECURITY NO. ✓	17. INFORMANT AND ADDRESS Mrs. Grace Proctor Shady Side Md			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Heart Failure	5 min.
420.2 Antecedent cause(s)		
93d Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Myocarditis - Angina Pectoris	1 year
	(c)	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	None	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? ~~Yes~~ No ☑
21. ACCIDENT SUICIDE HOMICIDE (Specify) No	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)	
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 11/25, 1949, to 11/26, 1949, that I last saw the deceased alive on 11/26, 1949, and that death occurred at 8:45 A.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

[illegible] Md. Shadyside Md

23. ~~BURIAL/CREMATION~~ REMOVAL ~~(Specify)~~	DATE Nov 26, 1949	NAME OF CEMETERY OR CREMATORY Denny Funeral Home	LOCATION (City, town, or county) (State) Balto. Md.
DATE REC'D BY LOCAL REG. Nov. 27-1949	REGISTRAR'S SIGNATURE J. B. Dent	24. FUNERAL DIRECTOR D. A. Hardisty & Son	ADDRESS Galesville Md

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

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BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

10395

CERTIFICATE OF DEATH

Reg. Dist. No. 28

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Crownsville, Md.; LENGTH OF STAY (in this place); HOSPITAL OR INSTITUTION OR STREET ADDRESS Crownsville State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Balti. City; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore; STREET ADDRESS (If rural, give location) Not known

3. NAME OF DECEASED (Type or Print): (First) Stephen (Middle) (Last) Evans

4. DATE OF DEATH: (Month) (Day) (Year) 11/30/49 19

5. SEX: male

6. COLOR OR RACE: colored

7. SINGLE, ~~MARRIED~~, ~~WIDOWED~~, ~~DIVORCED~~. (Specify) single

8. DATE OF BIRTH: ~~not known~~

9. AGE last birthday: 62(?) yrs. If under 1 year: Months, Days; If under 24 hrs.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): laborer

10b. KIND OF BUSINESS OR INDUSTRY: none

11. BIRTHPLACE (State or foreign country): Kentucky

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Louis Berry

14. MOTHER'S MAIDEN NAME: unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. *****

17. INFORMANT AND ADDRESS: Hospital Reocrds

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Chronic Myocarditis — known

422.2 Antecedent cause(s)

93d Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) — since six weeks

(c) Schizophrenia, Paranoid Type — known since 5/20/35.

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION: **** 19b. MAJOR FINDINGS OF OPERATION: ******

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) ******* PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) **** (CITY OR TOWN) ***** (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) **** m. INJURY OCCURRED While at Work ☐ Not While At work ☐ HOW DID INJURY OCCUR? ******

22. I hereby certify that I attended the deceased from 5/20/35, 19..., to 11/30/49, 19..., that I last saw the deceased alive on 11/30/49, 19..., and that death occurred at 11:47 P. m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Crownsville, Maryland 12/1/49

23. BURIAL, CREMATION, REMOVAL (Specify) removal DATE Dec. 2 1949 NAME OF CEMETERY OR CREMATORY Hopkinsville, Ky. LOCATION (City, town, or county) Hopkinsville (State) Ky.

DATE REC'D BY LOCAL REG. Dec. 2, 1949 REGISTRAR'S SIGNATURE E.T. Joyce Locality 12-6-49

24. FUNERAL DIRECTOR J. B. Johnson ADDRESS Annapolis Md

RECEIVED
DEC 8 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

10396

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY A. A. MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY An Ar
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Linthicum — LENGTH OF STAY (in this place) 22 yrs	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Linthicum
HOSPITAL OR INSTITUTION OR STREET ADDRESS 413 Hawthorne Rd.	STREET ADDRESS (If rural, give location) 413 Hawthorne Rd.

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Fanny	Martha	Ford.	Nov.	20	1949

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months / Days / If under 24 hrs.: Hours / Min.
Female	White	Widow	Nov. 11 1861	88 yrs.	

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
None	—	Balto. County.	U.S.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Amos Carr	Mary Lancaster

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT AND ADDRESS
No	None	Mrs. Mary Ford.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Cardio-Vascular Disease	6 mos.
422.1 Antecedent cause(s) 93d Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Arteio-Sclerosis	20 yr.
	(c)	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from July, 1949, to Nov 20, 1949, that I last saw the deceased alive on Nov. 20, 1949, and that death occurred at 9 A m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Chas. L. Ball Jr	MD	Linthicum	Nov. 20 '49

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
BURIAL	Nov. 23, 1949	BALDWIN MEMORIAL	MILLERSVILLE,	MD.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Nov 22	L. J. DeAlba	Thomas W. Singleton	Glen Burnie, Md.

RECEIVED
NOV 25 1949
WASHINGTON, D. C.

17
88
6761

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

10397

CERTIFICATE OF DEATH

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY ANNE ARUNDEL; STATE MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN ODENTON; LENGTH OF STAY (in this place) 18 YRS.; HOSPITAL OR INSTITUTION OR STREET ADDRESS OLD FT. MEADE, ROAD.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE MARYLAND; COUNTY ANNE ARUNDEL; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN PATUXENT (RURAL ODENTON); STREET (If rural, give location) R.D. ADDRESS GAMBRILLS, MD.

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
JAMES	V.	FORWOOD	NOVEMBER	23	1949

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
MALE	WHITE	SINGLE	AUG. 8, 1888	61 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
SHEET METAL WORKER	ODD JOBS	WAVERLY, BALTIMORE, MD	U.S.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
THOMAS FORWOOD	MEKAB MELISSA

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
UNKNOWN	NONE	LEON SMITH, ODENTON, MD.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Coronary disease Coronary Thrombosis

420.1 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last 94a (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from Nov 23, 1949, to 11-23, 1949, that I last saw the deceased alive on Nov 26, 1949, and that death occurred at 6.00 P m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Thomas Nemon M.D. Millersville, Md. 11-24-49

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
BURIAL	Nov. 26 1949	WAUGH CHAPEL	RURAL ODENTON, MD

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Nov 25	L. J. DeCelle	Thomas W. Singleton	Glen Burnie Md.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

10398

Reg. Dist. No.....

1. PLACE OF DEATH: COUNTY Anne Arundel — STATE MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Severn P.O. — LENGTH OF STAY (In this place) 1 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS Queenstown Road

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY A.A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Severn P.O.
STREET ADDRESS (If rural, give location) Queenstown Road

3. NAME OF DECEASED (Type or Print): (First) JOHN (Middle) (Last) FRANCIS

4. DATE OF DEATH: (Month) Nov. (Day) 7 (Year) 1949

5. SEX: Male

6. COLOR OR RACE: Negro

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married

8. DATE OF BIRTH: Sept. 6, 1884

9. AGE last birthday: 65 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY: Dec. Plant

11. BIRTHPLACE (State or foreign country): North Carolina

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: not Known

14. MOTHER'S MAIDEN NAME: not Known

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): World War I

16. SOCIAL SECURITY NO.

17. INFORMANT: Richard Francis

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Hemorrhage from rectum.	1 hour
467.2 Antecedent cause(s) Diseases or conditinns, if any, giving rise to the above cause stating the underlying cause last 123	(b) unknown	
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at work ☐ Not while at work ☐ | HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

John M. Gaffey M.D., Deputy Medical Examiner Annapolis Md. 11/7/49

23. BURIAL, CREMATION, REMOVAL (Specify): BURIAL | DATE THEREOF: 7/10/49 | NAME OF CEMETERY OR CREMATORY: BALTIMORE NATIONAL | LOCATION (City, town, or county) (State): BALTIMORE, Md.

DATE REC'D BY LOCAL REG. 11-8-49 | REGISTRAR'S SIGNATURE: J. W. Hedrick | 24. FUNERAL DIRECTOR: CHAS. R. LAW - 802 MADISON Ave ADDRESS: Balto. 1, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct one is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

10399

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY A.A. MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Ferndale
LENGTH OF STAY (in this place) 20 yr.
HOSPITAL OR INSTITUTION OR STREET ADDRESS # 2 Eugenia Ave.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Ann Ar.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Ferndale
STREET ADDRESS (If rural give location) # 2 Eugenia Ave.

3. NAME OF DECEASED (Type or Print) (First) Julia (Middle) A (Last) Gibson

4. DATE OF DEATH (Month) Nov. (Day) 21 (Year) 1949

5. SEX Female
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widow
8. DATE OF BIRTH 1857
9. AGE last birthday 92 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE
10b. KIND OF BUSINESS OR INDUSTRY —
11. BIRTHPLACE (State or foreign country) Talbot County Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME David Miller
14. MOTHER'S MAIDEN NAME Julia A Miller

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. —
17. INFORMANT Mrs. Violet Higgins

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
903.0 Immediate cause	(a) Hypostatic Pneumonia	1 week
186a Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Fracture rt. femur	Oct. 23-49
	(c) Arteriosclerosis	20 yr.

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) Accident
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) Ferndale (COUNTY) AA (STATE) Md.
TIME OF INJURY (Month) Oct. (Day) 23 (Year) 49 (Hour) 9 P m.
INJURY OCCURRED While at Work ☐ Not While At work ☑
HOW DID INJURY OCCUR? Fell on floor.

22. I hereby certify that I attended the deceased from Aug., 1938, to Nov. 21, 1949, that I last saw the deceased alive on Nov. 21, 1949, and that death occurred at 7:15 A m., from the causes and on the date stated above.

SIGNATURE Chas. L. Ball Jr (Degree or title) MD ADDRESS Linthicum DATE SIGNED Nov. 21/49

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE THEREOF 11-23-49.
NAME OF CEMETERY OR CREMATORY Teighman Meth.
LOCATION (City, town, or county) Teighman (State) Md

DATE REC'D BY LOCAL REG. 11/21/49
REGISTRAR'S SIGNATURE L. J. De Alba
24. FUNERAL DIRECTOR J. Leeds Moore ADDRESS Teighman Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
NOV 22 1949
BUREAU V. D.

Evidence for change in birth date shown on:

FILM No. G 122 NOV 28 1949

MARYLAND STATE DEPARTMENT OF HEALTH

10400

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No.

1. PLACE OF DEATH- COUNTY: Anne Arundel MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED- STATE: Maryland COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Freetown, P.O. Glen Burnie LENGTH OF STAY (In this place): 3 hrs.	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Baltimore,
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Marley Neck Road	STREET ADDRESS (If rural, give location): 209 Hill Street.

3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last): Henry Gore			4. DATE OF DEATH (Month) (Day) (Year): Nov. 13 1949		
5. SEX: Male	6. COLOR OR RACE: Colored	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married	8. DATE OF BIRTH: II/7/1908	9. AGE last birthday: 31 yrs.	If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Truck Driver	10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country): North Carolina, U.S.A.	12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME: Willie Gore			14. MOTHER'S MAIDEN NAME: Jettie Green		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No	16. SOCIAL SECURITY NO.: None		17. INFORMANT: Pearl Gore, 533 Paca St. Baltimore.		

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
982 Immediate cause	(a) Hemorrhage	Sudden
167 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Laceration of jugular vein (left)	Sudden
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒
21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☑ CAUSE OF DEATH.	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Friend's home	(CITY OR TOWN) (COUNTY) (STATE): Freetown (Glen Burnie) A.A. Md.
TIME OF INJURY (Month) (Day) (Year) (Hour): II -13-49 1.30 m.	INJURY OCCURRED While at work ☐ Not while at work ☒	HOW DID INJURY OCCUR? A "friend" slashed left side of neck

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☒, undetermined ☐.*

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Gustave H. Paulsen M.D.	assistant Co. medical examiner	Glen Burnie Md.	II/14/49

23. BURIAL, CREMATION REMOVAL (Specify): Burial	DATE THEREOF: 11/16/49	NAME OF CEMETERY OR CREMATORY: Whiteville N.C. A.C.L.	LOCATION (City, town, or county) (State): North Carolina
DATE REC'D BY LOCAL REG.: Nov. 16, 1949	REGISTRAR'S SIGNATURE: A. W. Hedrick	24. FUNERAL DIRECTOR: J. L. Brown & Son 108 W Montgomery St	ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

10401

Reg. Dist. No. .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15A

1. PLACE OF DEATH: COUNTY: ANNE ARUNDEL COUNTY — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: | LENGTH OF STAY (In this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Near Furnace Branch Rd., A. A. Co. (1 mile n. of G.B.)

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Maryland — COUNTY: a a.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Brooklyn,
STREET ADDRESS (If rural, give location): 3810 8th St.,

3. NAME OF DECEASED (Type or Print): (First) LILLIAN (Middle) (Last) GRAF

4. DATE OF DEATH: (Month) November (Day) 17, (Year) 1949

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)

8. DATE OF BIRTH: About 1918

9. AGE Last birthday: 31 yrs. | If under 1 year: Months | Days | If under 24 hrs.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY: Easton Box. Co.

11. BIRTHPLACE (State or foreign country): Baltimore

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME: Szczepkowski

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Henry Graf

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

891.5 **Immediate cause** (a) Asphyxiation due to carbon monoxide poisoning

178 B **Antecedent cause(s)** Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☒ No ☐

21. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH. | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY Lonely Road | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) Nov. (Day) 16-17 (Year) 49 (Hour) m. | INJURY OCCURRED While at work ☐ Not while at work ☒

HOW DID INJURY OCCUR? (radiator boiled over motor stopped) Inhalation of carbon monoxide fumes

22. *I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE: R S Fisher (Degree or title) M.D ADDRESS: 700 Fleet Street, Balto. City. DATE SIGNED: 11-17-49

23. BURIAL, CREMATION, REMOVAL (Specify): Burial | DATE THEREOF: Nov. 21 '49 | NAME OF CEMETERY OR CREMATORY: Holy Cross | LOCATION (City, town, or county): A.A. Co. (State)

DATE REC'D BY LOCAL REG.: Nov. 19 1949 | REGISTRAR'S SIGNATURE: R.D. | 24. FUNERAL DIRECTOR: Fred W Ozazewski | ADDRESS: 1936 Eastern Ave

Evidence for additions of #2,7,8,9,11,12,13,14,15 16,17 shown on:

FILM No. G 123 DEC 1 - 1949

10402

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 8 44 21

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
LENGTH OF STAY (In this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Emergency Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Georgia COUNTY unk.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Summerville
STREET ADDRESS (If rural, give location) Route #7

3. NAME OF DECEASED (Type or Print) (First) LOYD (Middle) J. R. (Last) GREEN

4. DATE OF DEATH (Month) NOV. (Day) 22 (Year) 1949

5. SEX MALE
6. COLOR OR RACE WHITE
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single
8. DATE OF BIRTH 10 Nov. 1924
9. AGE last birthday 25 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pvt. U.S.A
10b. KIND OF BUSINESS OR INDUSTRY 806 ENG. AVN BN
11. BIRTHPLACE (State or foreign country) Trion Georgia
12. CITIZEN OF WHAT COUNTRY? U.S.A. Yes

13. FATHER'S NAME HARVEY GREEN
14. MOTHER'S MAIDEN NAME Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES (If yes, give war or dates of service) Present
16. SOCIAL SECURITY No. unknown
17. INFORMANT Service Record

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Crushed Chest

8195

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

170C

(c) accident

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Multiple fractures.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☒ No ☐

21. EXTERNAL CAUSE WAS PRIMARY ☑ OR CONTRIBUTING ☐ CAUSE OF DEATH.
PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY (CITY OR TOWN) NEAR WHITEMARSH (COUNTY) PRINCE GEORGE (STATE) MD
TIME OF INJURY (Month) NOV. (Day) 22 (Year) 1949 (Hour) 3.00 A.m.
INJURY OCCURRED While at work ☐ Not while at work ☑
HOW DID INJURY OCCUR? automobile hit bridge abutment

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE John M. Claffy M.D. (Degree or title) Deputy Medical Examiner ADDRESS Annapolis Md DATE SIGNED Nov. 22, 1949

23. BURIAL, CREMATION REMOVAL (Specify) Removal
DATE THEREOF 11/24/49
NAME OF CEMETERY OR CREMATORY
LOCATION (City, town, or county) (State) Summerville, Ga.

DATE REC'D BY LOCAL REG. 22 Nov 49
REGISTRAR'S SIGNATURE K E Crossman 1st Lt USAF(MC)
24. FUNERAL DIRECTOR W. W. Chambers Co ADDRESS 517-11 st SE

Dr. Wm. J. French J.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

RECEIVED
DEC 1 1949
BUREAU V. S.

Dr. Allen

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

10403

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural, Annapolis
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural, Annapolis
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED (Type or Print) (First) Oliver (Middle) Leslie (Last) Green

4. DATE OF DEATH (Month) 11 (Day) 29 (Year) 1949

5. SEX Male

6. COLOR OR RACE colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) widow

8. DATE OF BIRTH Oct. 14, 1846

9. AGE last birthday 103 yrs. If under 1 year Months 1 Days 15 If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Minister

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Skidmore, Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Samuel Green

14. MOTHER'S MAIDEN NAME Minnie Green

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY No.

17. INFORMANT Rev. Charles Green

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Coronary Occlusion

420.1

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

94a

(c)

INTERVAL BETWEEN ONSET AND DEATH

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 11-26, 1949, to 11-29, 1949, that I last saw the deceased alive on 11-29, 1949, and that death occurred at 8 40 p m., from the causes and on the date stated above.

SIGNATURE G. T. Allen (Degree or title) MD ADDRESS 10 Carroll DATE SIGNED 12-2-49

23. BURIAL, CREMATION REMOVAL (Specify) Burial

DATE THEREOF Dec. 4, 1949

NAME OF CEMETERY OR CREMATORY Broadneck

LOCATION (City, town, or county) (State) Skidmore, Md

DATE REC'D BY LOCAL REG. Dec. 2, 1949

REGISTRAR'S SIGNATURE [signature]

24. FUNERAL DIRECTOR J.B. Johnson, Annapolis, Md. ADDRESS

RECEIVED
DEC 8 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

10404

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 22

1. PLACE OF DEATH: COUNTY ANNE ARUNDEL STATE MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural - Laurel Md. | LENGTH OF STAY (in this place) 10 Month
HOSPITAL OR INSTITUTION OR STREET ADDRESS District Training School Laurel Md.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Washington D.C. COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Washington D.C
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print): (First) Jean (Middle) Dale (Last) Hale
4. DATE OF DEATH: (Month) 11 (Day) 26 (Year) 1949
5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single
8. DATE OF BIRTH: 10/17/1944
9. AGE last birthday: 4 Years (yrs.) | If under 1 year: Months | Days | If under 24 hrs.: Hours | Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10b. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (State or foreign country): Washington D.C.
12. CITIZEN OF WHAT COUNTRY? U.SA
13. FATHER'S NAME: Judson Joel Jones
14. MOTHER'S MAIDEN NAME: Jean Dale Hale
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT AND ADDRESS: Records of District Training School Laurel Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Acute Broncho Pneumonia	1 Day
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Malnutrition	4 Years
	(c) Mental Deficiency (Idiot)	4 Years

3250
107

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4/15/49, 19....., to 11/25....., 1949, that I last saw the deceased alive on 11/25/49, 19....., and that death occurred at 4:30 A.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) M.D. ADDRESS Medical Officer District Training Sch Laurel Md. DATE SIGNED 11/27/49

23. BURIAL, CREMATION, REMOVAL (Specify) Burial | DATE Nov. 28, 1949 | NAME OF CEMETERY OR CREMATORY Washington National | LOCATION (City, town, or county) Suitland, (State) Md.

DATE REC'D BY LOCAL REG. 11-27-49 | REGISTRAR'S SIGNATURE Clara Caslow | 24. FUNERAL DIRECTOR W.W. CHAMBERS, ADDRESS Riverdale, Md

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
DEC 8 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 1027

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Anne Arundel
City or town Jessups
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Severn — Ridge Rd.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Anne Arundel
City or town Jessups
(If outside city or town limits, write RURAL and give nearest town)
Street No. Severn — Ridge Rd.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME OLIVER HARRIS

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Single

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 21, 1886

8. AGE: Years	Months	Days	If less than one day
63	10	3	hrs. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual occupation Farmer
11. Industry or business

FATHER
12. Name Samuel Harris
13. Birthplace Md.

MOTHER
14. Maiden name Maria Gambrill
15. Birthplace Md.

16. Informant Mr. John A. Harris
Address Severn, Jessups, A. A. Co., Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11-27-49 (month) (day) (year)
Cemetery or crematory Gambrill's
Location Gambrill's, A. A. Co., Md.

18. Funeral director Mrs. Frances A. Hemsley
Address 578 W. Biddle St.

19. Nov 28 1949 (Date rec'd by registrar) Clara Kasbick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 24, 1949 at 10:35 M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Nov. 16th 49 to Nov. 24 49
and that I last saw him alive on Nov. 22nd 49

Immediate cause of death	DURATION
Cerebral Haemorrhage	8 days.
Due to Hypertension	2yrs.
Due to	
Other conditions	

331
83a
(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Frank Shipley, M. D. / M. D. or other
Address Savage, Md. Date signed 11/25/49

RECEIVED
DEC 8 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

10406

CERTIFICATE OF DEATH

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: ~~Ann~~ Homewood.
COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Homewood - Annapolis | LENGTH OF STAY (in this place) 2½ Mon.
~~HOSPITAL OR~~ INSTITUTION OR ~~STREET ADDRESS~~ Homewood Convalescent Home

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Va. COUNTY Fauquier
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Upper Ville
STREET ADDRESS (If rural give location) None - Rockcliff Farm ✓

3. NAME OF DECEASED (Type or Print): (First) Mary (Middle) Amelia (Last) Herwig

4. DATE OF DEATH: (Month) Nov. (Day) 30 (Year) 1949

5. SEX: F

6. COLOR OR RACE: W

7. SINGLE, MARRIED, ~~WIDOWED~~, DIVORCED, (Specify) W

8. DATE OF BIRTH: Oct. 1, 1857

9. AGE last birthday: 92 yrs. If under 1 year: Months Days; If under 24 hrs.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Alexandria, Va.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Robert Wilson Wheat

14. MOTHER'S MAIDEN NAME: Susan Harper

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Mrs. Benj. Dutton (daughter)

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

331 Immediate cause (a) Cerebral Vascular Accident — Interval Between Onset and Death: 3 days

83a Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Arteriosclerosis, Generalized — ?

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. —

19a. DATE OF OPERATION: None

19b. MAJOR FINDINGS OF OPERATION: —

20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) No

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY — (CITY OR TOWN) — (COUNTY) — (STATE)

TIME OF INJURY (Month) — (Day) — (Year) — (Hour) — m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR? —

22. I hereby certify that I attended the deceased from Sept. 13, 1949, to Nov. 30, 1949, that I last saw the deceased alive on Nov. 30, 1949, and that death occurred at 10:55 P.M., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Frank M. Shipley M.D. 63 College Ave. Annapolis, Md. 11/30/49

23. BURIAL, ~~CREMATION~~ REMOVAL (Specify) | DATE THEREOF 12-2-49 | NAME OF CEMETERY OR CREMATORY Arlington National | LOCATION (City, town, or county) (State) Arlington Va

DATE REC'D BY LOCAL REG. Dec. 1, 1949 | REGISTRAR'S SIGNATURE [illegible] | 24. FUNERAL DIRECTOR ADDRESS John M. Taylor for Annapolis Md.

RECEIVED
DEC 3 1949
BUREAU V. S.

10407

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH — COUNTY: A. A. — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Ferndale — LENGTH OF STAY (in this place): 24 yr.
HOSPITAL OR INSTITUTION OR STREET ADDRESS: #5 Annapolis Rd.

2. USUAL RESIDENCE (HOME) OF DECEASED — STATE: MD — COUNTY: A. A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: FERNDAL
STREET ADDRESS (If rural, give location): #5 ANNAPOLIS RD

3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last): Peter Holzinger
4. DATE OF DEATH (Month) (Day) (Year): Nov. 5 1949
5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)
8. DATE OF BIRTH: Feb. 23 - 1887
9. AGE last birthday: 62 yrs. — If under 1 year: Months, Days — If under 24 hrs.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Dore Keeper.
10b. KIND OF BUSINESS OR INDUSTRY: Grocery Store
11. BIRTHPLACE (State or foreign country): Austria
12. CITIZEN OF WHAT COUNTRY? Citizen
13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Unknown
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If year, give war or dates of service): N.
16. SOCIAL SECURITY No.: 215-03-2460
17. INFORMANT AND ADDRESS: Matthew Holzinger 2227 WEST LENNOTON ST.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

422.1 Immediate cause (a) Cardio-Vascular Disease — 7 days

Antecedent cause(s)

93d Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Gastric Haemorrhage — 10 days

(c)

II. OTHER SIGNIFICANT CONDITIONS — Conditions contributing to the death but not related to the disease or condition causing death. Diaphragmatic Hiernia — —

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURRED While at Work ☐ Not While At work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Feb., 1948, to Nov. 5, 1949, that I last saw the deceased alive on Nov. 5, 1949, and that death occurred at 5:45 P.m., from the causes and on the date stated above. 11/5/49

SIGNATURE: Chas. L. Ball — (Degree or title): J. M. D. — ADDRESS: Linthicum — DATE SIGNED: md.

23. BURIAL, CREMATION REMOVAL (Specify): BURIAL — DATE: NOV. 9 '49 — NAME OF CEMETERY OR CREMATORY: GLEN HAVEN — LOCATION (City, town, or county) (State): GLENBURNIE

DATE REC'D BY LOCAL REG.: 11/8/49 — REGISTRAR'S SIGNATURE: H. W. Heduck — 24. FUNERAL DIRECTOR: Harry H. Wilzin — ADDRESS: 4101 EDMONDSON AVE

3 m.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

Evidence for addition of #9 shown on:

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

10408

FILM No. G 123 DEC 5 1949

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY Emergancy Hosp. Annapolis, MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Emergancy Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE 91 Clay St. COUNTY Annapolis, AA MD.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN
STREET ADDRESS (If rural give location) Franklin

3. NAME OF DECEASED (Type or Print) (First) Charles (Middle) (Last) Jackson

4. DATE OF DEATH (Month) 11 (Day) 20 (Year) 1949

5. SEX Male

6. COLOR OR RACE Brown

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) ✓

8. DATE OF BIRTH ~~11-20-49~~ approx.

9. AGE last birthday ~~Unknown~~ 82 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY None

11. BIRTHPLACE (State or foreign country) Unknown

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Mr. Daniel A. Jackson

14. MOTHER'S MAIDEN NAME Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY No. Unknown

17. INFORMANT Unknown

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) cerebral hemorrhage	Nov 5th 49
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) arteriosclerosis	to Nov 20th
	(c) terminal lobar pneumonia	1949

331

108

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. hemiplegia rt side

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Nov 5th, 1949, to Nov 20th, 1949, that I last saw the deceased alive on Nov 20th, 1949, and that death occurred at 5:15 P m., from the causes and on the date stated above.

SIGNATURE Edith Rodler (Degree or title) M.D. ADDRESS 42 State Circle Annapolis Md DATE SIGNED 11-22-49

23. BURIAL, CREMATION REMOVAL (Specify) Burial

DATE THEREOF 11-24-49

NAME OF CEMETERY OR CREMATORY Brewer Hill

LOCATION (City, town, or county) Annapolis, (State) MD.

DATE REC'D BY LOCAL REG. Nov. 24, 1949

REGISTRAR'S SIGNATURE [signature]

24. FUNERAL DIRECTOR C. William Reese II ADDRESS 108 Washington, Street, Annapolis

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
NOV 29 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

10409

Reg. Dist. No. 28

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Crownsville
LENGTH OF STAY (in this place) 1 yrs 11 mos.
HOSPITAL OR INSTITUTION OR STREET ADDRESS Crownsville State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
STREET ADDRESS (If rural, give location) Sylvan Retreat

3. NAME OF DECEASED (Type or Print) (First) Edward (Middle) (Last) Jackson

4. DATE OF DEATH (Month) 11 (Day) 2 (Year) 1949

5. SEX Male

6. COLOR OR RACE Negro

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single

8. DATE OF BIRTH 1864

9. AGE last birthday 85 yrs. If under 1 year Months. Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Barber

10b. KIND OF BUSINESS OR INDUSTRY none

11. BIRTHPLACE (State or foreign country) West Virginia

12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME Robert Jackson

14. MOTHER'S MAIDEN NAME Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT AND ADDRESS Hospital Records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 2 days

331

Antecedent cause(s)

83a

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) General arteriosclerosis — Since admission 1/4/48

(c) Senile Psychosis

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan. 4, 1948, to Nov. 2, 1949 that I last saw the deceased alive on Nov. 2, 1949, and that death occurred at 3:30A.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Jack Manchester M.D. Crownsville, Maryland 11/2/49

23. BURIAL, CREMATION REMOVAL (Specify) Burial

DATE 11-10-49

NAME OF CEMETERY ~~OR CREMATORY~~ Hospital

LOCATION (City, town, or county) (State) Crownsville Md

DATE REC'D BY LOCAL REG. 11-10-49

REGISTRAR'S SIGNATURE E F Joyce Loscey

24. FUNERAL DIRECTOR Supt Hospital Crownsville Md

ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

I

RECEIVED
OCT 14 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

10410

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY A. A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis — LENGTH OF STAY (in this place) 29	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
HOSPITAL OR INSTITUTION OR STREET ADDRESS 239 Hanover	STREET ADDRESS (If rural, give location) 239 Hanover

3. NAME OF DECEASED (Type or Print) (First) RACHAEL (Middle) S. (Last) JENNINGS

4. DATE OF DEATH (Month) NOV. (Day) 5, (Year) 1949

5. SEX Female

6. COLOR OR RACE negro

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single

8. DATE OF BIRTH Feby. 22, 1872

9. AGE last birthday 77 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None

10b. KIND OF BUSINESS OR INDUSTRY —

11. BIRTHPLACE (State or foreign country) Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME MOSES H. JENNINGS

14. MOTHER'S MAIDEN NAME Harriet C. Brown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No

16. SOCIAL SECURITY No. none

17. INFORMANT Daniel T. Jennings

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Starvation	?
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Insanity	1 year
	(c)	

309

84d

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☑

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

John M. Caffy M.D., Deputy Medical Examiner, Annapolis Md 10-5-49

23. BURIAL, CREMATION, REMOVAL, (Specify) Burial — DATE THEREOF 11/8/49 — NAME OF CEMETERY OR CREMATORY St. Mary's — LOCATION (City, town, or county) Annapolis, Md. (State)

DATE REC'D BY LOCAL REG. Nov. 7, 1949 — REGISTRAR'S SIGNATURE [signature] — 24. FUNERAL DIRECTOR Charles E. Hicks — ADDRESS Ann. Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

M

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T

RECEIVED
MAY 8 1969
BUREAU U.S.

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF STILLBIRTH

Reg. Dist. No. 10411e8

A certificate must be filed within 24 hours for every stillbirth of 20 weeks' gestation or more (see stub)

1. PLACE OF BIRTH:
   County ANNE ARUNdel
   City or town Wilson Town
   (If outside city or town limits, write RURAL and give nearest town)
   Street address, hospital, or institution; Odenton Md.
   Length of mother's stay in County 4 yrs.
   (How many years, or months, or days? SPECIFY WHICH)

2. USUAL RESIDENCE OF MOTHER:
   State MARYLAND
   County A & Co Wilsontown
   City or town Baltimore Odenton
   (If outside city or town limits, write RURAL and give nearest town)
   Street No. ~
   (If RURAL give LOCATION)

3. Name of child
4. Date of birth Nov 3 1949 Hour 1 A. M.
5. Sex Female | 6. Twin or triplet
7. No. of weeks pregnancy 32

FATHER OF CHILD

8. Full name William Johnson
9. Color Colored 10. Age at time of this birth 29 yrs.
11. Usual occupation Labor

MOTHER OF CHILD

12. Full maiden name Nancy Lee Harrison
13. Color Colored 14. Age at time of this birth 28 yrs.
15. Usual occupation Housewife

16. Other children born to mother (not including present child): (a) How many children of this mother are now living? none
(b) How many other children were born alive but are now dead? none (c) How many other children were born dead? none

17. Did child die before labor? NO During labor?
18. Pregnancy, complications of None.
19. Labor: (a) Complications of
(b) Induced?
20. (a) Was there an operation for delivery? no (Yes or No)
(b) State all operations, if any
(c) Did child die before operation?
During operation?

21. Cause of stillbirth. Please be specific. For terms like prematurity, asphyxia, etc., try to add cause thereof.
(a) Fetal causes Prematurity - 7 Months
776 (b) Maternal causes
159

22. I certify to the birth of this child who was born dead* on the date and hour above stated.
Signature Edward Merritt M.D.
(Specify if M. D., midwife, or other)
Address Odenton Md.

23. (a) burial (b) Date thereof 11/4/49
(Burial, cremation or removal) (month) (day) (year)
(c) Cemetery or crematory Ford Church
24. (a) Funeral director John Shorter
(b) Address Odenton, Md

25. (a) 11/4/49 (Date rec'd by registrar) (b) E T Joyce (Registrar)

26. (To be filled out if no physician was present at delivery.) The above certificate has been examined by me.
Health Officer, per

V. S. A10

* See Instruction C on stub.

Wilsontown.

1949
U. S.

10412

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. ~~245~~ 26

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Bristol P.O. LENGTH OF STAY (In this place) —
HOSPITAL OR INSTITUTION OR STREET ADDRESS Pig Point

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Prince George
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Hyattsville
STREET ADDRESS (If rural, give location) 3901 Jefferson ✓

3. NAME OF DECEASED (Type or Print) (First) ARTHUR (Middle) L. (Last) JOHNSON
4. DATE OF DEATH (Month) Nov. (Day) 14 (Year) 1949

5. SEX MALE
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH May 30. 1894
9. AGE last birthday 55 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Contractor
10b. KIND OF BUSINESS OR INDUSTRY Electrical
11. BIRTHPLACE (State or foreign country) North Carolina
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Charles E. Johnson
14. MOTHER'S MAIDEN NAME Margaret V. Mitchell

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) World War I
16. SOCIAL SECURITY NO.
17. INFORMANT Juanita Johnson

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Drowning

929.8 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Accidental

183

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. EXTERNAL CAUSE WAS PRIMARY ☑ OR CONTRIBUTING ☐ CAUSE OF DEATH.
PLACE (Home, farm, factory, street, office bldg. etc.) OF INJURY Patuxent River near (CITY OR TOWN) Bristol P.O. (COUNTY) A.A. (STATE) Md.
TIME OF INJURY (Month) Oct. (Day) 31 (Year) 1949 (Hour) about 31 p.m.
INJURY OCCURRED While at work ☐ Not while at work ☐
HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE John McCaffey, M.D., (Degree or title) Deputy Medical Examiner, ADDRESS Annapolis, Md. DATE SIGNED 11/14/49

23. BURIAL, CREMATION REMOVAL (Specify) BURIAL
DATE THEREOF Nov. 16/1949
NAME OF CEMETERY OR CREMATORY FORT LINCOLN CEM.
LOCATION (City, town, or county) COLMAR MANOR (State) Md

DATE REC'D BY LOCAL REG. Nov 14, 1949
REGISTRAR'S SIGNATURE ~~James Serry~~ Ida Belle Dent
24. FUNERAL DIRECTOR W. W. CHAMBERS C. ADDRESS Riverdale M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

RECEIVED
NOV 10 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

10413

CERTIFICATE OF DEATH

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH
COUNTY: Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Annapolis
LENGTH OF STAY (in this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 116 Calvert Street

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland — COUNTY: Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Annapolis
STREET ADDRESS (If rural give location): 116 Calvert Street

3. NAME OF DECEASED (Type or Print): (First) Horace (Middle) (Last) Johnson

4. DATE OF DEATH: (Month) 11 / (Day) 29 / (Year) 1949

5. SEX: Male

6. COLOR OR RACE: Colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed

8. DATE OF BIRTH: 7/10/1868

9. AGE last birthday: 81 yrs. — If under 1 year: Months 4 Days — If under 24 hrs.: Hours Min. 19

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Domestic

10b. KIND OF BUSINESS OR INDUSTRY: none

11. BIRTHPLACE (State or foreign country): Skidmore A.A. Co. Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Clarence Johnson

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

443 **Immediate cause** (a) Apoplexy — 2days

93d **Antecedent cause(s)** Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Hypertensive Cardio Vascular Disease

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 11-28-49 19..... to 11-29-49 19....., that I last saw the deceased alive on 11-29-49 19....., and that death occurred at 7:P.M. m., from the causes and on the date stated above.

SIGNATURE (Degree or title): Sheridan D. Johnson M. D. — ADDRESS: 40 Northwest Street — DATE SIGNED: 12-1-49

23. BURIAL, CREMATION REMOVAL (Specify): Burial — DATE THEREOF: 12/2/49 — NAME OF CEMETERY OR CREMATORY: Ausbury Cemetery — LOCATION (City, town, or county) (State): Annapolis, Maryland

DATE REC'D BY LOCAL REG.: Dec. 2, 1949 — REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR — ADDRESS: Mrs. Charles E. Hicks & Son 45 Northwest st.

VS. A15

RECEIVED
DEC 3 1949
BUREAU V. S.

BUREAU V. S.

10414

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 28

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15A

1. PLACE OF DEATH: COUNTY Anne Arundel; MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Gambrills; LENGTH OF STAY (in this place); HOSPITAL OR INSTITUTION OR STREET ADDRESS Pole Hill Road

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md; COUNTY Anne Arundel Co.; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Conway (Gambrills P.O.); STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print): (First) George (Middle) Edward (Last) Jones

4. DATE OF DEATH: (Month) Nov. (Day) 13 (Year) 1949

5. SEX: Male

6. COLOR OR RACE: Negro

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Unknown

8. DATE OF BIRTH: Unknown

9. AGE last birthday: 85? yrs. If under 1 year: Months; Days. If under 24 hrs.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer (ret.)

10b. KIND OF BUSINESS OR INDUSTRY: farm

11. BIRTHPLACE (State or foreign country):

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: not known

14. MOTHER'S MAIDEN NAME: Mary Jones

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): unknown

16. SOCIAL SECURITY NO.:

17. INFORMANT: Charles Jones

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Senility — INTERVAL BETWEEN ONSET AND DEATH:

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Exposure — 12 days

9338 195e

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Found in woods apparently unable to get up. Was missing 12 days

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☑

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY:

(CITY OR TOWN) (COUNTY) Anne Arundel (STATE) Md.

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

John M. Cosby M.D. Deputy Medical Examiner Annapolis Md. 11/14/49

23. BURIAL, CREMATION, REMOVAL (Specify) Burial | DATE THEREOF Nov. 14 1949 | NAME OF CEMETERY OR CREMATORY Brewer Hall | LOCATION (City, town, or county) Annapolis | (State) Md.

DATE REC'D BY LOCAL REG. Nov 14, 1949 | REGISTRAR'S SIGNATURE E.T. Joyce Forsyth Reg. | 24. FUNERAL DIRECTOR J. B. Johnson | ADDRESS Annapolis

RECEIVED
NOV 17 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

10415

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH: COUNTY: ANNE ARUNDEL COUNTY MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN:
LENGTH OF STAY (in this place):
~~HOSPITAL OR~~ INSTITUTION OR STREET ADDRESS: Near Furnace Branch Road, A. A. Co., 1 mile n. of G.B.)

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Maryland COUNTY: Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN:
STREET ADDRESS (If rural, give location): Marley Road

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
WALTER	SMITH	JONES	November	17,	1949

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
Male	White	married	3/31/1913	36 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10b. KIND OF BUSINESS OR INDUSTRY: Easton Box. Co.
11. BIRTHPLACE (State or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Major Jones
14. MOTHER'S MAIDEN NAME: Reba F. Elliott

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): WW2
16. SOCIAL SECURITY NO.:
17. INFORMANT: Family - Same

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Asphyxiation due to carbon monoxide poisoning

891.5 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last 178 B

(b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? Yes ☒ No ☐

21. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.
PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: Lonely Road
(CITY OR TOWN): Near Furnace Br. Rd. 1 mile north of Glen Burnie
(COUNTY): A. A.
(STATE): Maryland
TIME OF INJURY (Month) (Day) (Year) (Hour): November 16-17 49 m.
INJURY OCCURRED While at work ☐ Not while at work ☒
HOW DID INJURY OCCUR? (radiator boiled over) Inhalation of carbon monoxide fumes (motor stopped)

22. *I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE: R S Fisher (Degree or title): M D ADDRESS: 700 Fleet Street DATE SIGNED: November 17, 1949

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
B	11/21/49	Cedar Hill	Baltimore	

DATE REC'D BY LOCAL REG. 11/21/49
REGISTRAR'S SIGNATURE: [illegible]
24. FUNERAL DIRECTOR: James L. McCauley ADDRESS: 130 E. Fort Ave

Dr

VS. A15A

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

10416

Reg. Dist. No. 28

1. PLACE OF DEATH COUNTY: A. A. MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED STATE: Md COUNTY:
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Crownsville — LENGTH OF STAY (in this place): 2 months + 27 days	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Balto City
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Crownsville State Hospital	STREET ADDRESS (If rural, give location): 812 Fremont Ave
3. NAME OF DECEASED (Type or Print) (First) Paul (Middle) K (Last) Keller	4. DATE OF DEATH (Month) 11. (Day) 20 (Year) 1949
5. SEX: M. — 6. COLOR OR RACE: C — 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): single	8. DATE OF BIRTH: March 28th 07 — 9. AGE last birthday: 42 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired): odd jobs. — 10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country): Md. — 12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Harris Keller	14. MOTHER'S MAIDEN NAME: Emma Smith
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service) — 16. SOCIAL SECURITY NO.	17. INFORMANT AND ADDRESS: Hospital Record

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

353.3 Immediate cause (a) Idiopathic Epilepsy — Man since admission

Antecedent cause(s)

85 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from August 22nd, 1949, to November 20th, 1949, that I last saw the deceased alive on Nov. 1st, 1949, and that death occurred at 5 30 A.m., from the causes and on the date stated above.

SIGNATURE: Jacob Hauguston M.D. (Degree or title) — ADDRESS: Crownsville Md — DATE SIGNED:

23. BURIAL, CREMATION REMOVAL (Specify): Removal	DATE: 11-23-49	NAME OF CEMETERY OR CREMATORY: Mt Auburn Cem	LOCATION (City, town, or county) (State): Balto. Md.
DATE REC'D BY LOCAL REG.: 11-20-49	REGISTRAR'S SIGNATURE: Ethel Joyce L R	24. FUNERAL DIRECTOR: Mrs Frances A. Hensley W. Biddle	ADDRESS: 578

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
APR 22 1988

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

10417

CERTIFICATE OF DEATH

Reg. Dist. No. 26

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH
COUNTY ANNE ARUNDEL MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN RURAL, CHURCHTON
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS CHALK POINT ROAD

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE MARYLAND COUNTY A.A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN RURAL, CHURCHTON
STREET ADDRESS (If rural, give location) CHALK POINT ROAD.

3. NAME OF DECEASED (Type or Print) (First) MARY (Middle) ELIZABETH (Last) KIRCHNER

4. DATE OF DEATH (Month) NOV. (Day) 8 (Year) 1949

5. SEX FEMALE

6. COLOR OR RACE WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) WIDOWED

8. DATE OF BIRTH AUG. 4 1865

9. AGE last birthday 84 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE

10b. KIND OF BUSINESS OR INDUSTRY NONE

11. BIRTHPLACE (State or foreign country) MARYLAND

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME TYDINGS.

14. MOTHER'S MAIDEN NAME NOT KNOWN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If year, give war or dates of service)

16. SOCIAL SECURITY NO. NONE

17. INFORMANT AND ADDRESS DAUGHTER, MRS. DONALD FORD, CHURCHTON

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

331 Immediate cause (a) CEREBRAL HEMORRHAGE — INTERVAL BETWEEN ONSET AND DEATH: 7 DAYS.

Antecedent cause(s)

83a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) ARTERIO SCLEROSIS. — NOT KNOWN

(c) SENILITY

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from NOV. 1st, 1949, to NOV. 8, 1949, that I last saw the deceased alive on NOV. 8, 1949, and that death occurred at 2.30 P. m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Nathaniel E. Lancaster M.D. Churchton P.O. Md. Nov. 8, 1949

23. BURIAL, CREMATION, ~~REMOVAL (Specify)~~ BURIAL — DATE 11-10-49 — NAME OF CEMETERY OR CREMATORY Quaker — LOCATION (City, town, or county) (State) Edgesville Md.

DATE REC'D BY LOCAL REG. NOV 9-49 — REGISTRAR'S SIGNATURE J. B. Dent

24. FUNERAL DIRECTOR T A. HARDESTY & SON — ADDRESS Edgesville Md

RECEIVED
NOV 11 1949
BUREAU V. S.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

10418

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY ANNE ARUNDEL MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN SEVERNA PARK (RURAL)
LENGTH OF STAY (In this place) 28 YEARS
HOSPITAL OR INSTITUTION OR STREET ADDRESS OLD ANNAPOLIS BLVD.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE MARYLAND COUNTY ANNE ARUNDEL
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN SEVERNA PARK (RURAL)
STREET ADDRESS (If rural, give location) OLD ANNAPOLIS BLVD (NEAR ROBINSON)

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
PAUL	FREDERICK	KNAPP	NOV.	11	1949

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
MALE	WHITE	MARRIED	DEC. 1, 1892	57 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
AUTOMOBILE MECHANIC.	FALLSWAY MOTORS	BALTIMORE, MD	U.S.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
WILLIAM FREDERICK KNAPP	PAULINE (UNKNOWN)

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
YES. WORLD WAR I	216-02-7129	MRS. IDA KNAPP.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause (420.1)	(a) Coronary Occlusion	30 minutes
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (93d)	(b) Chronic myocarditis	1 year
	(c) Enlarged Heart.	1 year

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
—	—	Yes ☐ No ☑

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
NO	—			

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED White at Work ☐ Not White At work ☐	HOW DID INJURY OCCUR?
— m.		

22. I hereby certify that I attended the deceased from Nov., 19[illegible], to Nov. 6, 1949, that I last saw the deceased alive on Nov. 6, 1949, and that death occurred at 7:30 P. m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Gustave A. Fouke M.D.		Glen Burnie, Md.	11/12/49

23. BURIAL, CREMATION / REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
BURIAL	Nov. 14, 1949	BALTIMORE NATIONAL	BALTIMORE MD

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	FUNERAL DIRECTOR	ADDRESS
Nov 14, 1949	[signature]	J.W. Singleton	Glen Burnie, Md

RECEIVED
OCT 19 1949
BUREAU V. S.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

10419

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY ANNE ARUNDEL MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN (RURAL) MILLERSVILLE
LENGTH OF STAY (In this place) 1 YR.
HOSPITAL OR INSTITUTION OR STREET ADDRESS Crain Highway

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE MARYLAND COUNTY ANNE ARUNDEL
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN (RURAL) MILLERSVILLE.
STREET ADDRESS (If rural, give location) CRAIN HIGHWAY (NEAR DOOR'S CORNER)

3. NAME OF DECEASED (Type or Print) (First) LOUIS (Middle) B. (Last) KOSTKOWSKI

4. DATE OF DEATH (Month) NOV. (Day) 13 (Year) 1949

5. SEX MALE
6. COLOR OR RACE WHITE
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) SINGLE
8. DATE OF BIRTH NOV. 3 1948
9. AGE last birthday 1 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) BALTIMORE MD
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME BOLESLAW KOSTKOWSKI
14. MOTHER'S MAIDEN NAME JULIANNA HOPPA.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. NONE
17. INFORMANT BOLESLAW KOSTKOWSKI, MILLERSVILLE, MD

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

754.4 Immediate cause (a) Congenital Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: 1 year

105 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Acute Laryngitis

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec, 1948, to Nov 13, 1949, that I last saw the deceased alive on Nov 12, 1949, and that death occurred at 2.30 p.m., from the causes and on the date stated above.

SIGNATURE Edward G Chemitt (Degree or title) M.D. ADDRESS Cambrills Md DATE SIGNED 11-14-48

23. BURIAL, CREMATION REMOVAL (Specify) BURIAL
DATE THEREOF NOV. 15, 1949
NAME OF CEMETERY OR CREMATORY OUR LADY OF THE FIELD
LOCATION (City, town, or county) MILLERSVILLE, (State) MD.

DATE REC'D BY LOCAL REG. NOV 14 1949
REGISTRAR'S SIGNATURE L. J. DeAlba
24. FUNERAL DIRECTOR W Singleton, ADDRESS Glen Burnie Md.

MARYLAND STATE DEPARTMENT OF HEALTH

10420

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.....

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Anna Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis | LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Emergency Hosp.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY Anne Arundel Co.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Boulevard Park
STREET ADDRESS (If rural, give location) Pasadena, Md.

3. NAME OF DECEASED (Type or Print): (First) Joseph (Middle) C. (Last) Kotman

4. DATE OF DEATH: (Month) Nov (Day) 13 (Year) 1949

5. SEX: Male | 6. COLOR OR RACE: White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): married | 8. DATE OF BIRTH: Dec 5-1887 | 9. AGE last birthday: 62 yrs. | If under 1 year: Months. Days | If under 24 hrs.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Police B | 10b. KIND OF BUSINESS OR INDUSTRY: Balto City | 11. BIRTHPLACE (State or foreign country): Balto | 12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Louis P Kotmans | 14. MOTHER'S MAIDEN NAME: Rachel Cramer

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | (If year, give war or dates of service) | 16. SOCIAL SECURITY NO.: None | 17. INFORMANT: Elsie Kotmair

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

420.1 **Immediate cause** (a) Heart failure

Antecedent cause(s)

94a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Acute myocardial Infarction — 4 days.

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7 Nov., 19 49, to 13 Nov., 19 49, that I last saw the deceased alive on 12 Nov., 19 49, and that death occurred at 4 P.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) | ADDRESS | DATE SIGNED

Randall M. McLaughlin M.D. | Pasadena P.O. Md. | November 14, 1949

23. BURIAL, CREMATION, REMOVAL (Specify) Burial | DATE Nov 16-49 | NAME OF CEMETERY OR CREMATORY Holy Cross Cem | LOCATION (City, town, or county) (State) A. A. Co.

DATE REC'D BY LOCAL REG. 11-14-49 | REGISTRAR'S SIGNATURE A. W. Nebrich | 24. FUNERAL DIRECTOR Bernard C. Hunle | ADDRESS 121 E West St

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 10421 28

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Crownsville
LENGTH OF STAY (in this place) 2 yrs. 3 mos
HOSPITAL OR INSTITUTION OR STREET ADDRESS Crownsville State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY Baltimore City
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore
STREET ADDRESS (If rural, give location) None Given

3. NAME OF DECEASED (Type or Print): (First) Mary (Middle) (Last) Lewis

4. DATE OF DEATH: (Month) 11 (Day) 7 (Year) 1949

5. SEX: Female

6. COLOR OR RACE: Negro

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed

8. DATE OF BIRTH: 1871

9. AGE last birthday: 78 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY: - - - - - -

11. BIRTHPLACE (State or foreign country): Unknown

12. CITIZEN OF WHAT COUNTRY? ?

13. FATHER'S NAME: Overton Freeman

14. MOTHER'S MAIDEN NAME: Betty Timpson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): - - - -
(If year, give war or dates of service): - - - -

16. SOCIAL SECURITY NO.: - - - - - -

17. INFORMANT AND ADDRESS: Hospital Records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

331 Immediate cause (a) Cerebral accident — Interval Between Onset and Death: 4 days

Antecedent cause(s)

934 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Hypertensive- cardio-vascular disease — Since admission

gen. arteriosclerosis

(c) Cerebral arteriosclerosis — Known to us since admission

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death: Senile Psychosis

19a. DATE OF OPERATION: - - - - -

19b. MAJOR FINDINGS OF OPERATION: - - - - -

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): - - - - - -

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY: - - - -

(CITY OR TOWN) (COUNTY) (STATE): - - - - - - - - - - - - - - - - - -

TIME OF INJURY (Month) (Day) (Year) (Hour): - - - - m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR? - - - - - - - - - - - - - - - - - -

22. I hereby certify that I attended the deceased from Aug. 8, 1947, to Nov. 7, 1949, that I last saw the deceased alive on Nov. 7, 1949, and that death occurred at 12:00 Noon m., from the causes and on the date stated above.

SIGNATURE (Degree or title): [signature] M.D. — ADDRESS: Crownsville, Maryland — DATE SIGNED: 11/7/49

23. BURIAL, CREMATION, REMOVAL (Specify): — DATE: 11-10-49 — NAME OF CEMETERY OR CREMATORY: Ruther Glen — LOCATION (City, town, or county) (State): Ruther Glen, Va.

DATE REC'D BY LOCAL REG. 11-8-49 — REGISTRAR'S SIGNATURE: E. Joyce Local Reg.

24. FUNERAL DIRECTOR: Charles W. Edwards — ADDRESS: Bowling Green, Va.

RECEIVED
NOV 11 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

10422

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH: COUNTY A. A. — CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis — LENGTH OF STAY (in this place) — MARYLAND — HOSPITAL OR INSTITUTION OR STREET ADDRESS Emergency Hospt

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md — COUNTY A A — CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Spa Road nr. Annapolis — STREET ADDRESS (If rural, give location) Annapolis R. 7, B.

3. NAME OF DECEASED (Type or Print): (First) THEODORE (Middle) H. (Last) LINTHICUM

4. DATE OF DEATH: (Month) Nov. (Day) 13 (Year) 1949

5. SEX: M

6. COLOR OR RACE: White

7. SINGLE, ~~MARRIED~~, WIDOWED, DIVORCED, (Specify)

8. DATE OF BIRTH: 12-16-1884

9. AGE last birthday: 64 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): A A Co Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Theodore H. Linthicum

14. MOTHER'S MAIDEN NAME: Georgiana Mitchell

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Marie Linthicum Annapolis R7.T. Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

845.5 **Immediate cause** (a) Fracture Base of Skull — INTERVAL BETWEEN ONSET AND DEATH: 11 hours

171b **Antecedent cause(s)** Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☑

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. — PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY Spa Road — (CITY OR TOWN) rear Annapolis — (COUNTY) A.A. — (STATE) Md.

TIME OF INJURY (Month) (Day) (Year) (Hour): Nov. 12. 1949 3:15 p.m. — INJURY OCCURRED While at work ☐ Not while at work ☑ — HOW DID INJURY OCCUR? Horse ran away and cart tipped over on head.

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE: John M. Caffey M.D. — (Degree or title) Deputy Medical Examiner — ADDRESS Annapolis, Md. — DATE SIGNED 11/13/49

23. BURIAL, ~~CREMATION~~, ~~REMOVAL~~ (Specify) — DATE THEREOF 11-15-49 — NAME OF CEMETERY OR CREMATORY Cedar Bluff — LOCATION (City, town, or county) Annapolis — (State) Md

DATE REC'D BY LOCAL REG. Nov. 14, 1949 — REGISTRAR'S SIGNATURE W. D. Branch — 24. FUNERAL DIRECTOR John M. Tayla. Son — ADDRESS Annapolis Md

VS. A15A

RECEIVED
NOV 15 1949
BUREAU V. S.

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

I

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

10423

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE MARYLAND COUNTY Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Crownsville — LENGTH OF STAY (Hospital place) [illegible] Smos.	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Molley
HOSPITAL OR INSTITUTION OR STREET ADDRESS Crownsville State Hospital	STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) (First) Harriett (Middle) (Last) McGee			4. DATE OF DEATH (Month) 11 (Day) 12 (Year) 1949		
5. SEX Female	6. COLOR OR RACE Negro	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Divorced	8. DATE OF BIRTH 1877	9. AGE last birthday 72 yrs.	If under 1 year Months. Days; If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME George Howard			14. MOTHER'S MAIDEN NAME Unknown		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)	16. SOCIAL SECURITY No.		17. INFORMANT AND ADDRESS Hospital Records		

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Myocardial Degeneration	12/13/41
443 Antecedent cause(s)	(b) Hypertension	
93d Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(c) Schizophrenia	Known to us since adm. 3/2/27

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10/13/, 1941 to 11/12/, 1949, that I last saw the deceased alive on 11/12/, 1949 and that death occurred at 1:15 A.m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Acab Mouzenstern M.D.		Crownsville, Maryland	11/12/49

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	11/18/49	Hallo Memorial	A. A. Co., Md

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Nov. 17, 1949	A. W. Hedrick	D. L. Brown & Son 108 W Montgomery St	

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

10424

CERTIFICATE OF DEATH

Reg. Dist. No. 23

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Crownsville
LENGTH OF STAY (in this place) 1 month
HOSPITAL OR INSTITUTION OR STREET ADDRESS Crownsville State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Balt. City
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore
STREET ADDRESS (If rural, give location) 1115 N. Carrolton Ave.

3. NAME OF DECEASED (Type or Print): (First) Walter (Middle) (Last) McKinney

4. DATE OF DEATH (Month) 11/7/49 (Day) (Year) 19

5. SEX: male

6. COLOR OR RACE: colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): ~~not known~~ since 1889

8. DATE OF BIRTH: ~~not known~~

9. AGE last birthday: 60(?) yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): not known

10b. KIND OF BUSINESS OR INDUSTRY: none

11. BIRTHPLACE (State or foreign country): not known

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: not known

14. MOTHER'S MAIDEN NAME: not known

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service): ***

16. SOCIAL SECURITY NO.: ***

17. INFORMANT AND ADDRESS: not known

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

450.0 **Immediate cause** (a) Generalized Arteriosclerosis — Interval between onset and death: known since admission

Antecedent cause(s)

97 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: ***

19b. MAJOR FINDINGS OF OPERATION: ***

20. AUTOPSY? Yes ☐ No ☐ ***

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): *** PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: ** (CITY OR TOWN): *** (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour): *** m. INJURY OCCURRED While at Work ☐ Not While At work ☐ HOW DID INJURY OCCUR? ***

22. I hereby certify that I attended the deceased from 10/5/49, 19..., to 11/7/49, 19..., that I last saw the deceased alive on 11/7/49, 19..., and that death occurred at 12:40 P. m., from the causes and on the date stated above.

SIGNATURE: [illegible] M.D. (Degree or title) ADDRESS: Crownsville, Maryland DATE SIGNED: 11/7/49

23. BURIAL, CREMATION, REMOVAL (Specify): burial | DATE: 11/10/49 | NAME OF CEMETERY OR CREMATORY: Mount Auburn | LOCATION (City, town, or county) (State): Baltimore, Maryland

DATE RECD BY LOCAL REG. 11/8/49 | REGISTRAR'S SIGNATURE: [illegible] | 24. FUNERAL DIRECTOR: Mr. George Kelson | ADDRESS: " "

VS. A13

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

10425

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH
COUNTY: Anne Arundel — STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Rural Severna Park
LENGTH OF STAY (in this place): 5 months
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Cedar Crest Nursing Home

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland — COUNTY:
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Baltimore
STREET ADDRESS (If rural, give location): 1714 St. Paul Street

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Cleon	B.	Moore, Jr.	Nov.	28,	1949

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
Male	White	Single	Feb. 15, 1873	76 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Real Estate	Own Business	Charlestown W.Va.	U.S.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Cleon B. Moore Sr.	Ellen D. Rutherford

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
Unknown	Unknown	Melvin T. Strider, Charlestown, W.Va.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Generad Arterio-sclerosis	5 months
450.0 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last 97	(b) Senility	?
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
—	—	Yes ☐ No ☑

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
—	—			

TIME OF INJURY (Month)	(Day)	(Year)	(Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
—			m.	—	

22. I hereby certify that I attended the deceased from June, 1949, to Nov., 1949, that I last saw the deceased alive on Nov. 25, 1949, and that death occurred at 8:30 A. m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Eustace H. Boucher M.D.		Glen Burnie, Md.	11/29/49

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Nov. 30, 49	Edge Hill	Charlestown, W.Va.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
11/28/49	[signature]	Thomas W. Singleton, Glen Burnie, Md.	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
NOV 29 1949
BUREAU V. S.

Evidence for addition in #2,7,8,9,11,12,13,14,15, 16,17 shown on:

FILM No. G 123 DEC 1 - 1949

10426

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 245 21

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
LENGTH OF STAY (In this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Emergency Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Mississippi COUNTY unk.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Grenada
STREET ADDRESS (If rural, give location) Route #4 Box 164

3. NAME OF DECEASED (Type or Print) (First) HERBERT (Middle) LEROY (Last) O'BRIEN
4. DATE OF DEATH (Month) NOV. (Day) 22 (Year) 1949
5. SEX MALE
6. COLOR OR RACE WHITE
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single
8. DATE OF BIRTH 14 Apr. 31
9. AGE last birthday 18 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PVT. U.S. Army
10b. KIND OF BUSINESS OR INDUSTRY 806 ENG. AV. BN
11. BIRTHPLACE (State or foreign country) Grenada Mississippi
12. CITIZEN OF WHAT COUNTRY? Yes
13. FATHER'S NAME unknown
14. MOTHER'S MAIDEN NAME Vinie O'Brien (Maiden name unk)
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES (If yes, give war or dates of service) Present
16. SOCIAL SECURITY No. unk.
17. INFORMANT Service Record

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

819.5 Immediate cause (a) Fracture of Skull

170 c Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c) accident

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Multiple fractures

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. EXTERNAL CAUSE WAS PRIMARY ☑ OR CONTRIBUTING ☐ CAUSE OF DEATH.
PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY PRIEST'S BRIDGE NEAR WHITEMARSH (CITY OR TOWN) PRINCE GEORGE (COUNTY) (STATE) MD.
TIME OF INJURY (Month) Nov. (Day) 22 (Year) 1949 (Hour) 3:00 A.m.
INJURY OCCURRED While at work ☐ Not while at work ☑
HOW DID INJURY OCCUR? Automobile hit bridge abutment.

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE John M. Claffey (Degree or title) M.D. Deputy Medical Examiner ADDRESS Annapolis Md. DATE SIGNED Nov. 22, 1949

23. BURIAL, CREMATION REMOVAL (Specify) Removal
DATE THEREOF Nov. 24 1949
NAME OF CEMETERY OR CREMATORY —
LOCATION (City, town, or county) Washington Grenada (State) Miss.

DATE REC'D BY LOCAL REG. 22 Nov 49
REGISTRAR'S SIGNATURE K E Cussman 1st Lt USAF (MSC)
24. FUNERAL DIRECTOR W. W. Chambers Co ADDRESS 517-11 St SE

Dr. Wm. J. French G.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

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DEC 1 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

10427

CERTIFICATE OF DEATH

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH
COUNTY: Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Eastport
LENGTH OF STAY (in this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 600 State Street

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland — COUNTY: Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Eastport
STREET ADDRESS (If rural, give location): 600 State Street

3. NAME OF DECEASED (Type or Print): (First) Annie (Middle) C (Last) Parks

4. DATE OF DEATH: (Month) 11 (Day) 10 (Year) 1949

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, ~~WIDOWED, DIVORCED~~ (Specify): Married

8. DATE OF BIRTH: May 11, 1867

9. AGE last birthday: 81 yrs. If under 1 year: Months / Days / If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Jonas Williams

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: William D. Parks

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Myocarditis chr. with Myocardial Insufficiency	Several years
422.1 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b)	
938	(c) Arteriosclerosis	Several years

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE):

TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from March, 1940, to Nov 10, 1949, that I last saw the deceased alive on Nov 10, 1949, and that death occurred at 9 PM m., from the causes and on the date stated above.

SIGNATURE (Degree or title): Grace L. Beail M.D. ADDRESS: Annapolis Md DATE SIGNED: 11-12-49

23. BURIAL, CREMATION, REMOVAL (Specify): DATE THEREOF: 11-13-49 NAME OF CEMETERY OR CREMATORY: Bay View Cemetery LOCATION (City, town, or county) (State): Annapolis Md

DATE REC'D BY LOCAL REG.: Nov. 13, 1949 REGISTRAR'S SIGNATURE:

24. FUNERAL DIRECTOR ADDRESS: John M. Taylor - Sr. Annapolis Md.

VS-A15

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NOV 15 1949
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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

10428

CERTIFICATE OF DEATH

Reg. Dist. No. 25

1. PLACE OF DEATH: COUNTY ANNE ARUNDEL MARYLAND MD
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS 406 ORCHARD AVE

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE MD COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN BROOKLYN. 25
STREET ADDRESS (If rural, give location) 406 ORCHARD AVE

3. NAME OF DECEASED (Type or Print) (First) WILLIAM (Middle) POLLOCK (Last) SR

4. DATE OF DEATH (Month) NOV (Day) 23 (Year) 1949

5. SEX MALE
6. COLOR OR RACE WHITE
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) MARRIED
8. DATE OF BIRTH MAY-11-1888
9. AGE last birthday 61 yrs. If under 1 year Months 6 Days 12 If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PAINTER
10b. KIND OF BUSINESS OR INDUSTRY PATAPSCO SCAPE CORP
11. BIRTHPLACE (State or foreign country) IRELAND
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME WILLIAM POLLOCK.
14. MOTHER'S MAIDEN NAME MARY DAVISON

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) — NO (If year, give war or dates of service) — NO
16. SOCIAL SECURITY No. 212-07-7306
17. INFORMANT MRS ROSE POLLOCK.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

			INTERVAL BETWEEN ONSET AND DEATH
163	Immediate cause	(a) Carcinoma of Lung	2 yrs.
	Antecedent cause(s)		
47d	Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b)	
		(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from April, 1948, to Nov., 1949, that I last saw the deceased alive on 11-21, 1949, and that death occurred at 7 30 p.m., from the causes and on the date stated above.

SIGNATURE P. J. Grimaldi M.D. (Degree or title) ADDRESS 4609 Gov. Ritchie Highway DATE SIGNED 11-24-49

23. BURIAL, CREMATION REMOVAL (Specify) BURIAL
DATE NOV 26-49
NAME OF CEMETERY OR CREMATORY CATHEDRAL CEM.
LOCATION (City, town, or county) BALTIMORE MD (State)

DATE REC'D BY LOCAL REG. 11/25/49
REGISTRAR'S SIGNATURE H. W. Heduck Dm
24. FUNERAL DIRECTOR Bernard C. Harle ADDRESS 121 E West St

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

10429

CERTIFICATE OF DEATH

Reg. Dist. No. 27

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

VS. A15

1. PLACE OF DEATH
COUNTY: Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Ft George G Meade
LENGTH OF STAY (in this place): 2 months
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Qrs 254-B

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland — COUNTY: Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Ft George G Meade
STREET ADDRESS (If rural give location): Qrs 254-B

3. NAME OF DECEASED (Type or Print): (First) WILLIAM (Middle) HARRISON (Last) PROVANCE Jr

4. DATE OF DEATH: (Month) November (Day) 23 (Year) 1949

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): single

8. DATE OF BIRTH: 11 Sep 1949

9. AGE last birthday: yrs. — If under 1 year: Months 2, Days 12, Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10b. KIND OF BUSINESS OR INDUSTRY: -

11. BIRTHPLACE (State or foreign country): Ft George G Meade Md

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: William Harrison Provance

14. MOTHER'S MAIDEN NAME: Elsie Mae Carpenter

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: -

17. INFORMANT: SFC William H Harrison, 19th Ord MM Co, Ft Geo G Meade Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Asphyxiation	Unknown
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Pulmonary edema	"
	(c) Probably due to bronchopneumonia	"

491
107

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. None

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION: None

20. AUTOPSY? Yes ☒ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY: (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept 11, 1949, to Nov 23, 1949, that I last saw the deceased alive on Nov 23, 1949, and that death occurred at 9/7 m., from the causes and on the date stated above.

SIGNATURE (Degree or title): Stanley L. Blume Lt Col MC — ADDRESS: Sta Hosp Ft Geo G Meade Md — DATE SIGNED: 23 Nov 49

23. BURIAL, CREMATION REMOVAL (Specify): Cremation — DATE THEREOF: 11/25/49 — NAME OF CEMETERY OR CREMATORY: Greenmount — LOCATION (City, town, or county) (State): Baltimore Md.

DATE REC'D BY LOCAL REG.: 23 Nov 49 — REGISTRAR'S SIGNATURE: JAMES E HAYES, Capt MSC — James E Hayes

24. FUNERAL DIRECTOR — ADDRESS: William Tickner Funeral Home, Bolto Md

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

10430

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY A. A. MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis; LENGTH OF STAY (in this place); HOSPITAL OR INSTITUTION OR STREET ADDRESS 45 Cornhill St

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY A. A.; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis; STREET ADDRESS (If rural give location) 45 Cornhill

3. NAME OF DECEASED (Type or Print)	(First)	(Middle)	(Last)	4. DATE OF DEATH	(Month)	(Day)	(Year)
	Robert	Viereck	Puckett		11	20	1949

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, ~~WIDOWED, DIVORCED,~~ (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
Male	White		6-20-1875	74 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY
Mason	Masonry	Annapolis Md	U.S.A.

13. FATHER'S NAME Joseph S. Puckett

14. MOTHER'S MAIDEN NAME Mary J. Williams

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Julia W. Puckett Annapolis Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Coronary Thrombosis	18 Hrs.
420.1 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last 94a	(b) Arterial Hypertension	several yrs.
	(c)	

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. none

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
no				

TIME OF INJURY (Month)	(Day)	(Year)	(Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
			m.		

22. I hereby certify that I attended the deceased from Nov 19, 1949, to Nov 20, 1949, that I last saw the deceased alive on Nov 20, 1949, and that death occurred at 12 30 P m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
J. Oliver Purves	M.D.	Annapolis Md	11/21/49

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
	11-23-49	Cedar Bluff	Annapolis	Md

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Nov 21, 1949		John W. Taylor Son	Annapolis Md.

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NOV 28 1949
BUREAU V. S.

10431

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH · COUNTY A.A. MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Johnson Clinic

2. USUAL RESIDENCE (HOME) OF DECEASED · STATE Md. COUNTY 17.17.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis, Md.
STREET ADDRESS (If rural give location) 18 college ave.

3. NAME OF DECEASED (Type or Print) (First) Gregory (Middle) Baby Rand (Last)

4. DATE OF DEATH (Month) 11 (Day) 23 (Year) 1949

5. SEX M
6. COLOR OR RACE Brown
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)
8. DATE OF BIRTH 11-20-49
9. AGE last birthday yrs. If under 1 year Months Days 3 If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Ann. Ar. Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Dalton Rand
14. MOTHER'S MAIDEN NAME Anatoria Cornel

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Dalton, Rand

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Congenital Brain Lesion — INTERVAL BETWEEN ONSET AND DEATH 3 days

753.1 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

87a (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Nov 20, 1949, to Nov 22, 1949, that I last saw the deceased alive on ....., 19..... and that death occurred at ..... m., from the causes and on the date stated above.

SIGNATURE Theodore H. Johnson (Degree or title) M.D. ADDRESS 40 Northwest Street Annapolis, Md. DATE SIGNED 11/25/49

23. BURIAL, CREMATION REMOVAL (Specify)
DATE THEREOF 11-28-49
NAME OF CEMETERY OR CREMATORY Brewer Hill Cemetery
LOCATION (City, town, or county) (State) Annapolis, Md.

DATE REC'D BY LOCAL REG. Nov. 25, 1949
REGISTRAR'S SIGNATURE [signature]
24. FUNERAL DIRECTOR Wm. Green II (E. G. Magee) ADDRESS 108 Washington St. Annapolis.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

Evidence for change of age shown on:

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

10432

FILM No. G 123 JAN 4 1950

CERTIFICATE OF DEATH

Reg. Dist. No. 22

1. PLACE OF DEATH: COUNTY A.A. MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Unknown COUNTY P.Geo.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Jessup — LENGTH OF STAY (in this place) 2 days	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Unknown (see over)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Md. House of Correction	STREET ADDRESS (If rural give location) Unknown

3. NAME OF DECEASED (Type or Print)	(First)	(Middle)	(Last)	4. DATE OF DEATH	(Month)	(Day)	(Year)
	Michael	E.	Reilly		11	30	1949

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
Male	White	Unknown	1893	56 ~~54~~ yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Unknown	Unknown	Unknown	U.S.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Unknown	Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
Unknown	Unknown	Patient

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause	(a) Edema of lungs.	
002 Antecedent cause(s)		
138 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Lobar Pneumonia.	2 days
	(c) Tuberculosis, pulmonary	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Mitral Insufficiency.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from Nov. 28, 1949, to Nov. 30, 1949, that I last saw the deceased alive on Nov. 30, 1949, and that death occurred at 10:35P m., from the causes and on the date stated above.

SIGNATURE John A. Clark M.D. (Degree or title) ADDRESS DATE SIGNED

John A. Clark M.D., Physician in Charge,-M.H.C.,Jessup,Md.- Dec.2, 1949

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
REMOVAL	12/8/49	U OF MD MEDICAL SCHOOL	GREENE ST	MD

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Dec 5-49	Clara Kaslup	DIPPEL BROS	1800 E LOMBARD ST.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15

Patient was admitted from the Magistrate Court, Prince Georges Co. See letter on file in Bur Div. of Tbc. Services. 1-24-50 ams.

Evidence for change of birth date shown on:

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

10433

FILM No. G 123 DEC 13 1949

CERTIFICATE OF DEATH

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY A. A. — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS 16 McKendree Ave

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY AA.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
STREET ADDRESS (If rural give location) 16 McKendree Ave

3. NAME OF DECEASED (Type or Print): (First) Elizabeth (Middle) Johnson (Last) Robins

4. DATE OF DEATH: (Month) 11 (Day) 21 (Year) 1949

5. SEX: F

6. COLOR OR RACE: W.

7. ~~SINGLE~~, ~~MARRIED~~, WIDOWED, ~~DIVORCED~~, (Specify)

8. DATE OF BIRTH: 3-18-49 87d

9. AGE last birthday: 79 yrs. If under 1 year: Months / Days. If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY: none

11. BIRTHPLACE (State or foreign country): Lancaster Va

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: John P. Johnson

14. MOTHER'S MAIDEN NAME: Sallie E. Lipscomb

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Albert S. Johnson Annapolis Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Coronary occlusion	1/2 day
420.1 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last 93d	(b) arteriosclerotic cardiovascular disease	(3)
	(c)	

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. none

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 11/20, 1949, to 11/21, 1949, that I last saw the deceased alive on 11/21, 1949, and that death occurred at 1:50 P m., from the causes and on the date stated above.

SIGNATURE J. Bosnick (Degree or title) M.D. ADDRESS DATE SIGNED 11/22/49

23. BURIAL, CREMATION, REMOVAL (Specify) | DATE THEREOF 11-23-49 | NAME OF CEMETERY OR CREMATORY Lester Manor | LOCATION (City, town, or county) King Williams Co (State) Va

DATE REC'D BY LOCAL REG. Nov. 22, 1949 | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR | ADDRESS John M. Taylor Son Annapolis Md.

VS. A15

RECEIVED
NOV 15 1949
BUREAU V. S.

DATE OF BIRTH & AGE: ARMY DISCHARGE AND AFFIDAVIT filmed G122 11/30 and 12/2/49 LL

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

10434

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 20

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Mayo
LENGTH OF STAY (In this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS in Selby Bay

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE District of Columbia COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Washington
STREET ADDRESS (If rural, give location) 214 Massachusetts Ave. N.E.

3. NAME OF DECEASED (Type or Print) (First) GLENN (Middle) WILLIAM (Last) SEAMAN
4. DATE OF DEATH (Month) Nov. (Day) 14 (Year) 1949

5. SEX Male
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH May 1894 1899
9. AGE last birthday 55 yrs. If under 1 year Months 5 Days 17 If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Government Position
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Ohio
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME W J Seaman
14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Not old War I
16. SOCIAL SECURITY NO.
17. INFORMANT

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Drowning

850.8 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Accidental

172 (c)

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. EXTERNAL CAUSE WAS PRIMARY ☑ OR CONTRIBUTING ☐ CAUSE OF DEATH.
PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY Selby Bay (CITY OR TOWN) Mayo (COUNTY) Anne Arundel (STATE) Md.
TIME OF INJURY (Month) Nov. (Day) 13 (Year) 1949 (Hour) 11.45 A. m.
INJURY OCCURRED While at work ☑ Not while at work ☑
HOW DID INJURY OCCUR? fell from his boat

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE John M. Claffey M.D. (Degree or title) Deputy Medical Examiner ADDRESS Annapolis, Md. DATE SIGNED 11/14/49

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE THEREOF Nov. 16, 1949
NAME OF CEMETERY OR CREMATORY Arlington Cem
LOCATION (City, town, or county) Arlington (State) Va

DATE REC'D BY LOCAL REG. Nov. 14, 1949
REGISTRAR'S SIGNATURE Edward Collenson
24. FUNERAL DIRECTOR Lee Funeral Home J Lee & Sons Co ADDRESS Wash. DC

RECEIVED
NOV 17 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

10435

Reg. Dist. No. 23

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY A. A. MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY A. A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Linthicum Hgts. LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Linthicum Hgts.
HOSPITAL OR INSTITUTION OR STREET ADDRESS 441 Hawthorne Rd.	STREET ADDRESS (If rural, give location) 441 Hawthorne Rd.

3. NAME OF DECEASED (Type or Print)	(First)	(Middle)	(Last)	4. DATE OF DEATH	(Month)	(Day)	(Year)
	CHARLES	P.	SHAFER		Nov.	20,	19 49

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
male	white	married	July 28, 1864	85 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Freight Conductor (rtd)	B. & O. R. R.	Baltimore, Md.	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Daniel R. Shafer	Priscilla Kelley

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
no		Mrs. Jeannette Shafer Linthicum Hgts. 441 Hawthorne Rd.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Cerebral Haemorrhage	4 mos.
422.1 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last 93d	(b) Arterio-Sclerosis	15 yrs.
	(c) Cardio-Vascular Disease	3 yrs.
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from Nov 16, 1936, to Nov 20, 1949, that I last saw the deceased alive on Nov 20, 1949, and that death occurred at 2 P. m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Chas. L. Ball Jr.	MD	Linthicum	Nov. 20/49

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	11/23/49	Loudon Park Cem.	Balto., Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
1/23/49	A. W. Hedrick	WM. J. TICKNER & SONS	Balto., Md.

VS-A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

10436

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH
COUNTY: A. A. Co. — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Annapolis
LENGTH OF STAY (in this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Emergency Hosp.

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland — COUNTY: A. A. Co.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Lake Shore
STREET ADDRESS (If rural give location):

3. NAME OF DECEASED (Type or Print): (First) John (Middle) Henry (Last) Shores

4. DATE OF DEATH: (Month) 11 (Day) 10 (Year) 1949

5. SEX: Male

6. COLOR OR RACE: White

7. ~~SINGLE~~, MARRIED, ~~WIDOWED~~, ~~DIVORCED~~, (Specify): Married

8. DATE OF BIRTH: Sept. 12. 1885

9. AGE last birthday: abt. 64 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Talbot Co. Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: John Shores

14. MOTHER'S MAIDEN NAME: Sarah R. Tyfer

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Roia E. Weaver - 1831 W. Pratt St.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Myocarditis Chr. with Myocardial Insufficiency	Several years.
422.1 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b)	
93d	(c) Arteriosclerosis	Several years

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE):

TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct 1, 1949, to Nov 10, 1949, that I last saw the deceased alive on Nov 10, 1949, and that death occurred at 2 P m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Geo. C Boeil	M D	Annapolis Md	11-10-49

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	11-12-1949	Marley Neck	Solley A. A. Co. Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
NOV. 12. 1949	R. W. L. W. Hedrick	Flynn + Fleming	1426 Light St.

VS. A15

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 21 10437

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Isabella Virginia Simms

2. DATE OF DEATH: Nov. 17, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland B.A. Co. Md

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 212 Miland Ave.

C. Length of stay in Baltimore: Life Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland B. COUNTY: A.A.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pumphrey

D. STREET ADDRESS (If rural, give location): 212 Miland Ave.

5. SEX: F

6. COLOR OR RACE: C

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): M.

8. DATE OF BIRTH: Sept 19, 1881

9. AGE (In years last birthday): 68 | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Baltimore

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.:

17. INFORMANT: Samuel Simms ADDRESS: 212 Miland ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hypo-static pneumonia

DUE TO

443 ANTECEDENT CAUSES

(B) Hypertensive Cardiovascular

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO Disease

177

(C) Food Poisoning

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 11/18, 1948 *to* 11-17, 1949 *that I last saw the deceased alive on* 11-17, 1949, *and that death occurred at* 6:15 P.m., *from the causes and on the date stated above.*

23A. SIGNATURE: R B Lighslow, M. D.

23B. ADDRESS: 601 Cherry Hill Road

23C. DATE SIGNED: 11/17/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: Nov. 20-49

24C. NAME OF CEMETERY OR CREMATORY: Mt Calvery Cem.

24D. LOCATION (City, town, or county) (State): Brooklyn Md

DATE RECEIVED BY LOCAL REGISTRAR: 11-18-49

REGISTRAR'S SIGNATURE:

25. FUNERAL DIRECTOR: Choy O. Wilson ADDRESS: 100 Brantley

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Cu. 1017

10438

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 21

M C I

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A1

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
LENGTH OF STAY (in this place) - - - - - -
HOSPITAL OR INSTITUTION OR STREET ADDRESS U.S.Naval Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN RURAL - Annapolis
STREET ADDRESS (If rural, give location) 63 Alder Road, MEMQ

3. NAME OF DECEASED (Type or Print): (First) Hura (Middle) Mae (Last) SINGLETON
4. DATE OF DEATH: (Month) 11 (Day) 27 (Year) 1949
5. SEX: Female
6. COLOR OR RACE: Negro
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single
8. DATE OF BIRTH: 11-27-49
9. AGE last birthday: - - - yrs. If under 1 year: Months - - Days - - If under 24 hrs.: Hours 2 Min. 55
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10b. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: James LeRoy Singleton Sr.
14. MOTHER'S MAIDEN NAME: Rebecca Heyward
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service) - - - -
16. SOCIAL SECURITY NO. - - - - -
17. INFORMANT AND ADDRESS: Hospital records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) PREMATURE BIRTH, NEONATAL DEATH — 3 hours

776 Antecedent cause(s)

159 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) TWENTY FIVE (25) WEEKS GESTATION

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION - - - - - - - -
19b. MAJOR FINDINGS OF OPERATION -
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify) - - - - - -
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) - - - - - (CITY OR TOWN) (COUNTY) (STATE) -
TIME OF INJURY (Month) (Day) (Year) (Hour) - - - - - - - - m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR? -

22. I hereby certify that I attended the deceased from 11-27-, 1949, to 11-27-, 1949, that I last saw the deceased alive on 11-27-, 1949, and that death occurred at 7:35 P. m., from the causes and on the date stated above.

SIGNATURE R.K. BROOKS B.K. Brooks (Degree or title) LT., MC, USN ADDRESS U.S.Naval Hospital, Annapolis, Md. DATE SIGNED 11-28-49

23. BURIAL, CREMATION REMOVAL (Specify) Burial DATE 11/29/49 NAME OF CEMETERY OR CREMATORY U.S. Naval Academy LOCATION (City, town, or county) (State) Naval Academy, Md.

DATE REC'D BY LOCAL REG. Nov. 29, 1949 REGISTRAR'S SIGNATURE [signature] 24. FUNERAL DIRECTOR Mrs. Charles E. Hicks & Son. ADDRESS

RECEIVED
NOV 30 1949
BUREAU V. S.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

10439

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Green Haven | LENGTH OF STAY (in this place) 30 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS Third Street

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Green Haven, Rural Pasadena
STREET ADDRESS (If rural give location) Third Street

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
George	Albert	Smith	Nov.	30	1949

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
Male	White	Married	March 4, 1866	83 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
None	None	Washington, D.C.	U.S.

13. FATHER'S NAME: Albert C. Smith
14. MOTHER'S MAIDEN NAME: Caroline Little

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
None	None	Colvin A. Smith, 1716 E. Pratt St. Baltimore, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Heart failure	30 min.
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Stomach trouble, malnutrition	
450.0 97	(c) Arteriosclerosis	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. none.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from Nov. 30, 1949, to Nov. 30, 1949, that I last saw the deceased alive on Dec 1, 1949, and that death occurred at 6:50 A.m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Randall M. McLaughlin	M.D.	Pasadena P.O. Md.	November 30, 1949

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Dec. 3, 1949	Glen Haven	Glen Burnie Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Dec 1. 1949	[signature]	[signature]	Glen Burnie, Md.

RECEIVED
DEC 3 1949
BUREAU V. S.

10440

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 26

1. PLACE OF DEATH COUNTY: Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Churchton
LENGTH OF STAY (in this place): 30 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Deale Road.

2. USUAL RESIDENCE (HOME) OF DECEASED STATE: Maryland COUNTY: A.A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Churchton
STREET ADDRESS (If rural, give location): Deale Road.

3. NAME OF DECEASED (Type or Print) (First) SYLVESTER (Middle) (Last) THOMPSON
4. DATE OF DEATH (Month) Nov. (Day) 26 (Year) 1949
5. SEX: MALE
6. COLOR OR RACE: NEGRO
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single
8. DATE OF BIRTH: MAY 26, 1899
9. AGE last birthday: 50 yrs. If under 1 year: Months / Days. If under 24 hrs.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): OYSTERING
10b. KIND OF BUSINESS OR INDUSTRY: SEA FOOD
11. BIRTHPLACE (State or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: James Thompson
14. MOTHER'S MAIDEN NAME: Dorcas Holland
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): None
16. SOCIAL SECURITY No.:
17. INFORMANT: Andrew Thompson

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

916.0 Immediate cause (a) Asphyxia

180 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Burns 3rd degree

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Trapped in burning house 3rd floor

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? Yes ☐ No ☑

21. EXTERNAL CAUSE WAS PRIMARY ☑ OR CONTRIBUTING ☐ CAUSE OF DEATH.
PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: at home
(CITY OR TOWN) Churchton (COUNTY) A.A. (STATE) Md
TIME OF INJURY (Month) Nov. (Day) 26 (Year) 1949 (Hour) 9.35 p.m.
INJURY OCCURRED While at work ☐ Not while at work ☑
HOW DID INJURY OCCUR? Trapped in burning house, 3rd floor

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE: John M. Claffy M.D. (Degree or title) Deputy Medical Examiner, ADDRESS: Annapolis Md DATE SIGNED: 11/26/49

23. BURIAL, CREMATION, REMOVAL (Specify): DATE THEREOF: Nov. 29-49 NAME OF CEMETERY OR CREMATORY: Franklin Cem LOCATION (City, town, or county): Churchton (State): Md.

DATE REC'D BY LOCAL REG.: Nov. 27. 49 REGISTRAR'S SIGNATURE: J. B. Dent
24. FUNERAL DIRECTOR: C. A. Hardisty & Son Galesville ADDRESS: Md

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

RECEIVED
NOV 29 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

10441

CERTIFICATE OF DEATH

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH · COUNTY: Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: West Annapolis
LENGTH OF STAY (in this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 310 Severn Ave.

2. USUAL RESIDENCE (HOME) OF DECEASED · STATE: Maryland — COUNTY: Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: West Annapolis
STREET ADDRESS (If rural give location): 310 Severn Ave.

3. NAME OF DECEASED (Type or Print): (First) Albert (Middle) L (Last) Touchard

4. DATE OF DEATH: (Month) 11- (Day) 29- (Year) 1949

5. SEX: Male

6. COLOR OR RACE: Whtie

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed

8. DATE OF BIRTH: July 28, 1875

9. AGE last birthday: 74 yrs. — If under 1 year: Months 4 Days 1 — If under 24 hrs.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Painting Carpenter

10b. KIND OF BUSINESS OR INDUSTRY: Self.

11. BIRTHPLACE (State or foreign country): Blatimore, Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Leapold Touchard

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mrs Charles J. Cammarata

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

420.0 **Immediate cause** (a) Coronary occlusion — 3 days

93d **Antecedent cause(s)** Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Arteriosclerotic Heart Disease — 10 yrs.

(c) Senility

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY — (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Aug 1, 1949, to 11-29-1949, that I last saw the deceased alive on 11-29-1949, and that death occurred at 8:05 p.m., from the causes and on the date stated above.

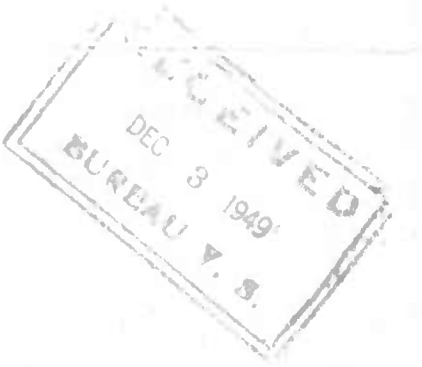
SIGNATURE: James R. Martin — (Degree or title): M.D. — ADDRESS: Annapolis, Md. — DATE SIGNED: 12-1-49

23. BURIAL, CREMATION · BURIAL (Specify) — DATE THEREOF: 12-3-49 — NAME OF CEMETERY OR CREMATORY: Loudon Park Cemetery — LOCATION (City, town, or county) (State): Baltimore, Maryland

DATE REC'D BY LOCAL REG.: Dec. 1, 1949 — REGISTRAR'S SIGNATURE: J. A. Church

24. FUNERAL DIRECTOR — ADDRESS: B. L. Hopping and Son — Annapolis, Md.

VS. A15


RECEIVED
DEC 3 1949
BUREAU V. S.

Evidence for change of birth date shown on:

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

10442

FILM No. G 123 DEC 8 1949

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Glen Burnie
LENGTH OF STAY (in this place) 25 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS 401 Delmar Ave. S.E.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Glen Burnie
STREET ADDRESS (If rural, give location) 401 Delmar Ave. S.W.

3. NAME OF DECEASED (Type or Print) (First) William (Middle) (Last) Voltz

4. DATE OF DEATH (Month) Nov. (Day) 30 (Year) 1949

5. SEX Male

6. COLOR OR RACE White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married

8. DATE OF BIRTH Nov. 27, ~~1949~~ 1877

9. AGE last birthday 72 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Barber

10b. KIND OF BUSINESS OR INDUSTRY Own Business

11. BIRTHPLACE (State or foreign country) Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME Dr. Herman Voltz

14. MOTHER'S MAIDEN NAME Mary Presser

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. None

17. INFORMANT Mrs. Carrie E. Voltz, Glen Burnie, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

			INTERVAL BETWEEN ONSET AND DEATH
151	Immediate cause	(a) Generalized carcinomatosis	6 mos.
46b	Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Carcinoma stomach	
		(c) Senility	

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. None

19a. DATE OF OPERATION None

19b. MAJOR FINDINGS OF OPERATION None

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7/1, 1949, to 11/30, 1949 that I last saw the deceased alive on 11/29, 1949, and that death occurred at 5.00 A.M., from the causes and on the date stated above.

SIGNATURE R.W. Richard (Degree or title) Md ADDRESS Glen Burnie, Md DATE SIGNED 11/30/49

23. BURIAL, CREMATION REMOVAL (Specify) Burial

DATE THEREOF Dec. 3, 49.

NAME OF CEMETERY OR CREMATORY Glen Haven

LOCATION (City, town, or county) Glen Burnie, (State) Md.

DATE REC'D BY LOCAL REG. 12/1/49

REGISTRAR'S SIGNATURE [signature]

24. FUNERAL DIRECTOR [signature] ADDRESS Glen Burnie, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
DEC 3 1949
BUREAU V. S.

ITEMS: 10 + 11
Phone call taken
from undertaker
11/30/49

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10443

Reg. Dist. No. .....

1. PLACE OF DEATH: Anne Arundel County

County Bayside Beach

City or town .....
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? .....

Hospital, institution, or street address where death occurred:

How long in hospital or institution? .....

2. USUAL RESIDENCE (HOME) OF DECEASED: Anne Arundel County
(For newborn infants give residence of mother)

State Md. County Bayside Beach

City or town .....
(If outside city or town limits, write RURAL and give nearest town)

Street No. .....
(If rural, give LOCATION)

2.(a) If veteran, name war .....

3.(a) FULL NAME William David Voss Sr.

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife Elisha Voss

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) July - 30 - 1867

8. AGE:

Years	Months	Days	If less than one day
82	3	21	..... hrs. ..... min.

9. Birthplace Germany
(Town, county, and state)

10. Usual occupation Laborer (Retired)

11. Industry or business Balto. Transit Co.

FATHER
12. Name Unknown
13. Birthplace Germany

MOTHER
14. Maiden name Unknown
15. Birthplace Germany

16. Informant Nannie E. Parrish

Address Jessups Md

17. Burial Date thereof Nov 24/1949
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory London Park

Location Baltimore Md.

18. Funeral director Maurice C Syfer

Address 1600 N. North Ave.

19. 11/23 1949 A W Hedrick
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 21 1949 at 6:50 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1949 to Nov. 21 1949 and that I last saw him alive on November 19 1949

Immediate cause of death	DURATION
Heart Failure	1 week
Due to Chronic Myocarditis	1 year
Due to Arteriosclerosis	5 years

Other conditions .....
422.1
93d
(Include pregnancy within 3 months of death)

Major findings of operations .....

Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE J. Brady Smith M.D.
M. D. or other

Address Riviera Beach Md. Date signed 11/21/49

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

10444

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Ann Arundel

City or town: Severna Park
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 weeks

Hospital, institution, or street address where death occurred: Cedar Crest Nursing Home.

How long in hospital or institution? 7 weeks

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: A. A.

City or town: Severn
(If outside city or town limits, write RURAL and give nearest town)

Street No. New Cut Road.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Mrs. CATHERINE WAIGAND.

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	White	Married

6.(b) Name of husband ~~or wife~~ Joseph Waigand

6.(c) If alive, give age 73 years

7. Birth date of deceased (mo., day, yr.) Dec. 18 - 1873

8. AGE: Years 75 | Months 10 | Days 12 | If less than one day ..... hrs. ..... min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER
12. Name: ? Smith
13. Birthplace: Maryland

MOTHER
14. Maiden name: Christine Stuchman.
15. Birthplace: Maryland.

16. Informant: Mr. Jos Waigand (husband)

Address: Severna Park, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov 4-1949 (month) (day) (year)

Cemetery or crematory: Holy Cross Cem.

Location: A. A. Co

18. Funeral director: Bernard C Harle

Address: 121 E West St

19. 11/2 1949 (Date rec'd by registrar) A. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 1st 1949 at 5 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 1947 to October 27 1949 and that I last saw her alive on October 27 1949

Immediate cause of death	DURATION
Cerebral Hemorrhage	6 hrs.
Due to Hypertension	4 months
Due to General Arterio-sclerosis - unknown	
Other conditions	

331
83a (Include pregnancy within 3 months of death)

Major findings of operations: None.

Date of op.

Autopsy results: None.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: NO Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Gustave H Fauber M.D. M. D. or other

Address: Glen Burnie Md. Date signed 11/1/49

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

10445

CERTIFICATE OF DEATH

Reg. Dist. No. 22

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY Anne Arundel; STATE MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Crofton; LENGTH OF STAY (in this place) 8 years; HOSPITAL OR INSTITUTION OR STREET ADDRESS New Cut Road

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY A. A.; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Odenton, Severn; STREET ADDRESS (If rural give location) New Cut Road.

3. NAME OF DECEASED (Type or Print): (First) HENRY (Middle) (Last) WISNIEWSKI

4. DATE OF DEATH: (Month) November (Day) 8 (Year) 1949

5. SEX: M

6. COLOR OR RACE: W

7. SINGLE, (MARRIED), WIDOWED, DIVORCED, (Specify)

8. DATE OF BIRTH: Sept 25, 1911

9. AGE last birthday: 38 yrs. If under 1 year: Months; Days; If under 24 hrs.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Crane operator

10b. KIND OF BUSINESS OR INDUSTRY: Shipyards

11. BIRTHPLACE (State or foreign country): Baltimore Md.

12. CITIZEN OF WHAT COUNTRY? USA.

13. FATHER'S NAME: Walter Wisniewski

14. MOTHER'S MAIDEN NAME: Helia Brongert

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 215-07-7952

17. INFORMANT: Helia Wisniewski, Mother

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) CARDIAC DECOMPENSATION — 2 years

416

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last — (b) RHEUMATIC HEART DISEASE

95b

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. none.

19a. DATE OF OPERATION: none

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) none

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY none (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) none m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from April, 1949, to NOVEMBER 1949, that I last saw the deceased alive on Nov 8, 1949, and that death occurred at 9 P. m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Bobby L. Jones, M.D. 7 Central Ave S.W. Glen Burnie 11/8/49

23. BURIAL, CREMATION REMOVAL (Specify) Burial

DATE THEREOF 11-12-49

NAME OF CEMETERY OR CREMATORY Holy Rosary

LOCATION (City, town, or county) (State) Balto. Co.

DATE REC'D BY LOCAL REG. 11/10/49

REGISTRAR'S SIGNATURE A. W. Hedrick

24. FUNERAL DIRECTOR ADDRESS Wm. J. Fialkowski 2007 Eastern Ave.

VS: A15

Evidence for change of age shown on;

10446

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

FILM No. G 122 NOV 25 1949

CERTIFICATE OF DEATH

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH · COUNTY: Anne Arundel — MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED · STATE: Maryland — COUNTY: Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Annapolis — LENGTH OF STAY (In this place): 48 Yrs.	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Annapolis
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 45 Calvert Street	STREET ADDRESS (If rural give location): 45 Calvert Street

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Ella	------	Young	11/	15/	19 49

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months / Days	If under 24 hrs.: Hours / Min.
Female	Colored	Married	1877	~~73~~ 72 yrs.	---- / ----	---- / ----

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Domestic	None	Anne Arundel Co. Md.	------

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
George Parker	Isabella Addison

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
No ------	None	Josephine Young

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Cerebro-vascular accident

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Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

83a

(b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from 11-1, 1949, to 11-15, 1949, that I last saw the deceased alive on 11-14, 1949, and that death occurred at 12 25 A.m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
G. T. Allen	M D	10 Carroll	11-16-49

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	11/ 17/ 1949	Brewer Hill Cemetery	West St. Extended- Annapolis

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Nov. 17, 1949	[signature]	Mrs. Charles E. Hicks	45 Northwest St.

RECEIVED
NOV 18 1949
BUREAU Y. S.